Kentucky’s health care choice

Member Handbook

WellCare®
WELCOME TO WELLCARE

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

- No co-pay $0 for generic drugs
- No co-pay $0 for tobacco cessation office visits
- Free monthly personal care items mailed directly to your home
- Unlimited prescription drugs
- Free flu shots
- 24-hour Nurse Advice Line

This handbook will tell you more about your benefits. We hope it will answer most of your questions. Visit us on the Web at kentucky.wellcare.com for 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 1-877-389-9457 (TTY 1-877-247-6272). We have friendly staff trained to answer all your questions Monday–Friday, 7 a.m. to 7 p.m. Eastern.

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 Kentucky

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WE’RE HERE TO HELP

You may call Customer Service when you need help from us.

HELP FROM CUSTOMER SERVICE

Our Customer Service representatives can answer many of your questions. You can reach them Monday through Friday, from 7 a.m. to 7 p.m. Eastern. Please feel free to call them anytime you have questions about:

- Benefits
- Replacing a lost ID card
- Filing a grievance (complaint)
- Changing your doctor
- Getting a list of doctors and drug stores in our network
- Getting materials in a different language or format

The toll-free Customer Service phone number is: 1-877-389-9457 (TTY 1-877-247-6272)

You can also contact Customer Service by writing to:

WellCare Customer Service
P.O. Box 438000
Louisville, KY 40253

If you do not speak English, we can help. We want you to know how to use your health care plan no matter what language you speak. Just call us and we will find a way to talk to you in your own language. We have translation services available. We also have information in large print, Braille and audible media. All of these services are available at no cost. Our TTY phone number is 1-877-247-6272.

### OTHER IMPORTANT PHONE NUMBERS

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>Customer Service</td>
<td>1-877-389-9457</td>
</tr>
<tr>
<td>TTY Service</td>
<td>1-877-247-6272</td>
</tr>
<tr>
<td>24-Hour Nurse Advice Line</td>
<td>1-800-919-8807</td>
</tr>
<tr>
<td>Transportation</td>
<td>1-888-941-7433</td>
</tr>
<tr>
<td>Behavioral Health Customer Service</td>
<td>1-855-620-1861</td>
</tr>
<tr>
<td>24-Hour Behavioral Health Crisis Hotline</td>
<td>1-855-661-6973</td>
</tr>
<tr>
<td>Avesis (vision)</td>
<td>1-855-776-9466</td>
</tr>
<tr>
<td>DentaQuest (dental)</td>
<td>1-855-806-5641</td>
</tr>
<tr>
<td>Kentucky Medicaid Member Services</td>
<td>1-800-635-2570</td>
</tr>
<tr>
<td>Kentucky Medicaid Enrollment Services</td>
<td>1-855-446-1245</td>
</tr>
</tbody>
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### Office of the Ombudsman

The Office of the Ombudsman for the Cabinet for Health and Family Services acts as an advocate for the people of Kentucky. It works to make sure people who get public services are treated fairly. You can contact them with complaints you may have.

To reach the office by phone: **1-877-807-4027** *(TTY 1-800-627-4702)*

Online: [http://chfs.ky.gov/os/omb](http://chfs.ky.gov/os/omb)

By mail:

The Office of the Ombudsman  
Cabinet for Health and Family Services  
275 E. Main St., 1E-B  
Frankfort, KY 40621
THE WELLCARE DICTIONARY

Advance Directive
A legal paper that tells your doctor and family how you wish to be cared for when you are ill and need care to prolong life. It goes into effect when you are so ill that you cannot make decisions for yourself.

Appeal
Requests you make when you do not agree with our decision to deny, cut back or end a service. Someone who represents you can also ask for an appeal.

Benefits
Health care we cover.

Complaint (same as Grievance)
When you let us know that you are not satisfied. You can do this in writing or tell us verbally. A complaint can be filed with or without justification.

Co-pays/Coinsurance
How much you must pay when getting care from WellCare providers.

Disenrollment
When you no longer wish to be a part of our plan, and the steps to follow to leave WellCare (voluntary). When Kentucky Medicaid says you are no longer able to be part of the our plan (involuntary).

Durable Medical Equipment
Medical items such as wheelchairs and oxygen tanks.

Emergency
A very serious medical condition. It must be treated right away.

Environmental Accessibility Adaptations
Changes to the home that are needed to ensure your health, welfare and safety. These also help you function on your own in the home.

EPSDT (Early and Periodic Screening, Diagnosis and Treatment)
Regular health exams for children. They are used to find and treat medical problems.
Generic Drug
A drug that has the same basic ingredients as a brand-name drug.

Grievances
When you let us know you are not satisfied with a provider, the plan or a benefit. You can do this in writing or tell us verbally.

Home Health Agency
A company that provides health care services in your home. These services are things such as nursing visits or therapy treatments.

Health Maintenance Organization (HMO)
A company that works with a group of doctors, pharmacies, labs and hospitals. They do this to give quality health care to their members (see also Managed Care Organization and Managed Care Plan).

Immunizations
Shots that prevent many serious diseases. There are some shots your child has to get before he or she can start day care or school in Kentucky.

Inpatient
A person who stays in a hospital for a period of time. This is usually longer than 24 hours.

Long-Term Care
Care and help for elderly or disabled people. It may take place at home, in the community or it may take place in an institution.

Managed Care Organization (MCO)
A health maintenance organization (HMO) or insurer that has a contract with the Department of Member Services (DMS).

Managed Care Plan
A plan that you can choose to help you with all your health care needs. Managed care plans like WellCare work with you, your PCP and other health providers to coordinate your health care. Providers include clinics, doctors, hospitals, pharmacies and others.

Medically Necessary Services
Medical services that are needed for you to get well and stay healthy.
Member
A person who has joined our plan.

Member ID Card
An identification (ID) card that shows you are a member of our plan.

Outpatient
A person who gets medical treatment, usually at a hospital, but does not need to stay overnight.

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.

Personal Care Items — Over-the-counter items offered by your plan. The personal care items will be mailed directly to your home each month. Some items include vitamins, medicines and diapers.

Pharmacy Network
A group of drug stores that members can use.

Post Stabilization
Services related to an emergency medical condition that are provided after you are stabilized in order to maintain or improve your condition.

Preferred Drug List (PDL)
Medicines approved by the Pharmacy and Therapeutics (P&T) Committee, which consists of doctors and pharmacists.

Prescription Medicine
A drug for which your doctor writes an order.

Primary Care Provider (PCP)
Your personal doctor or Advanced Practice Registered Nurse. He or she manages all your health care needs.
Prior Authorization
When we have to OK treatment or medicines ahead of time.

Providers
Those who work with the plan to give medical care. This includes doctors, hospitals, pharmacies, labs and others.

Referral
When your PCP sends you to see another health care provider.

Specialist
A doctor who works in a specific field of medicine.

Treatment
The care you get from doctors and facilities.

WIC (Women, Infants and Children)
A program that works with women, babies and children. It helps them with nutrition.
GETTING STARTED

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

1. Check your ID card and put it in a safe place

You should have received your WellCare member ID card in the mail. Keep this card and your Medicaid card with you at all times.

You’ll need your ID card each time you get medical services. This means that you need your card when you:

• See your primary care provider (PCP), a specialist or other provider
• Go to an emergency room, urgent care facility or a hospital for any reason
• Get medical supplies and prescriptions
• Have medical tests done

Call WellCare Customer Service as soon as possible if:

• You have not received your card yet
• Any of the information on the card is wrong
• You lose your card

2. Get to know your primary care provider (PCP)

Your PCP is your personal doctor or Advanced Practice Registered Nurse. Call your PCP as soon as possible to schedule a physical. In fact, if you just joined the plan, it’s a good idea to see your PCP within 90 days. Your PCP will treat you for most of your health care needs and can arrange specialists and hospital care if needed. He or she will give you checkups and shots. You can reach your PCP by calling his or her office. Your PCP’s name and telephone number will be printed on your ID card.

Our PCPs are trained in different specialties. They include:

• Family and internal medicine
• General practice
• Geriatrics
• Pediatrics
• Obstetrics/Gynecology (OB/GYN)
• Advanced Practiced Registered Nurse services
There are also times when a specialist can be your PCP, provided:

- You have a chronic condition and have a historical relationship with the specialist

AND

- The specialist and our medical director agree in writing to assume the responsibilities of the PCP

Please note that some providers may not perform some services based on religious or moral reasons.

3. Choosing your PCP

Most WellCare members must choose a primary care provider (PCP). You may have done this already. If not, one was assigned to you. The assignment was based on the following:

- Where you may have received services before
- Where you live
- Your language preference
- Availability of the PCP (if the PCP is accepting new patients)
- Gender (in the case of an OB/GYN, as the available PCP)

Some members don’t have to select a PCP. These include:

- Dual-eligible members
- Members who are presumptively eligible
- Disabled children
- Foster care

You can call Customer Service or visit us on the Web at kentucky.wellcare.com if you have questions about your PCP assignment or if you would like to make a change.

4. Changing your PCP

You can change your PCP. To do this, you can visit our website at kentucky.wellcare.com. Or you can complete the PCP change form that came with your new member welcome letter. You can also call Customer Service.

You can change your PCP at any time. If the change is made between the first and 10th days of the month, it will immediately become effective. Changes made after the 10th of the month will become effective the first day of the following month.
Welcome to WellCare.

We’ll send you a new ID card after we get the change request. We’ll also send a letter to let you know your PCP has been changed. Please keep using your old card to get services until your new card arrives in the mail. Once you receive your new ID card, make sure the information is correct. Then destroy the old one.

It’s easy to find a list of our PCPs:

- Look in your provider directory
- Visit our website at kentucky.wellcare.com
- Call Customer Service

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

5. How to get services before you have a PCP

You can get services after joining WellCare and before you have a PCP. Just look in the provider directory that came with this packet. Then select a provider who is a part of our network. You can also see a list of providers on the Web at kentucky.wellcare.com. Then call Customer Service. They will help you get the services you need until your ID card arrives with the PCP you have chosen or were assigned.

6. When your family’s size or address changes

Your family’s make-up or size may change while you are a member. (For example, you may have a baby or get married or have a death in the family.) If this happens, call your local Department of Community Based Services (DCBS), listed on this website: https://apps.chfs.ky.gov/Office_Phone/index.aspx?county=12. You can also call WellCare Customer Service at 1-877-389-9457 (TTY 1-877-247-6272).

Also let them know of your new address if you move.

7. Get to know your 24-Hour Nurse Advice Line

Our Nurse Advice Line is available to you at no cost. You can call the line 24 hours a day, 7 days a week, every day of the year. Call 1-800-919-8807. Call anytime someone in your family is sick or hurt or needs medical advice.

When you call, a nurse will ask you some questions about your problem. Tell him or her as much as you can — where it hurts, what it looks like and what it feels like. He or she can help you decide if you need to:
• Go to a doctor or the hospital
• Care for yourself at home

Call when you need help with problems like:

• Back pain
• Burns
• Colds/the flu
• Coughing
• Cuts
• Dizziness

A nurse is there to help. So call the Nurse Advice Line before you call a doctor or go to the hospital. In an emergency, go to the hospital or call 911 first.

8. In an emergency
For a MEDICAL EMERGENCY, go to the hospital or call 911. Please read the Emergency Services section of this book. It tells you how you can get care. It also gives examples of emergencies.

9. WellCare members have certain rights and responsibilities
You have rights as a plan member. You also have certain responsibilities. You can read about these on pages 71–73.

10. Call us for help
Questions? Call us. We can get translators for all languages. We have materials available in other languages, large print, audio tapes and Braille. Sign language services are also available for hearing-impaired members. All of these services are available at no cost. Call 1-877-389-9457 (TTY 1-877-247-6272) weekdays from 7 a.m. to 7 p.m. Eastern.

You can also contact Customer Service by writing to:

WellCare Customer Service
P.O. Box 438000
Louisville, KY 40253

You are now ready to begin using all of the benefits you get with WellCare. We look forward to serving you.
INFORMATION ABOUT SERVICES

WHAT SERVICES ARE COVERED?
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 necessary. This means services that:
- 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
- You may have to pay a co-payment — or “co-pay” for short — when you get care.

RECEIVING NON-COVERED SERVICES
You can still get a service that is not covered. However, you will have to pay the provider directly. We recommend that you and your provider make such an agreement in writing.

Not paying for services that are not covered will not result in a loss of Medicaid benefits.

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.
COVERED SERVICES FOR GLOBAL CHOICES

Global Choices is the benefit plan for most Kentucky Medicaid members. This plan covers basic medical services. This is not a complete list of services. If a service is not listed, there is no co-pay. Some service limits can be increased if the service is medically necessary (requires prior approval).

Contact Customer Service with questions you may have about what services are covered. Call 1-877-389-9457 (TTY 1-877-247-6272).

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<td>Co-pay exempt members</td>
<td>Non-KCHIP children, children under 19 years of age who are in foster care, pregnant women, hospice care members and members in personal care or family care homes</td>
</tr>
<tr>
<td>Maximum out of pocket (MOOP)</td>
<td>Maximum out of pocket (MOOP) is $225 per calendar year but not more than 5% of a family’s income per quarter</td>
</tr>
<tr>
<td>Acute admissions medical diagnoses</td>
<td>$50 per admission</td>
</tr>
<tr>
<td>Mental health admissions mental health</td>
<td>$0 per admission</td>
</tr>
<tr>
<td>Acute health care related to substance abuse and/or for detoxification</td>
<td>$0 per admission</td>
</tr>
<tr>
<td>Nursing facility services</td>
<td>$0 per visit; physician services at a nursing facility are covered</td>
</tr>
<tr>
<td>Community mental health center (CMHC) services</td>
<td>$0 per admission; inpatient therapeutic program for persons who require less than 24-hour-a-day care but more than outpatient counseling</td>
</tr>
<tr>
<td>Service</td>
<td>Cost-sharing and Details</td>
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</tr>
<tr>
<td>Psychiatric residential treatment facilities (PRTFs) (children ages 6 to 21)</td>
<td>$0 per visit; services are covered for residents ages 6 to 21 who need intensive treatment and a more highly structured environment than they can receive in family and other community-based alternatives to hospitalization</td>
</tr>
<tr>
<td>Transplant services</td>
<td>$0 per transplant service</td>
</tr>
<tr>
<td>Outpatient hospital</td>
<td>$3 per visit</td>
</tr>
<tr>
<td>Ambulatory surgery center (ASC)</td>
<td>$0 per visit</td>
</tr>
</tbody>
</table>
| Alternative birthing center                                           | • $0 per visit  
• Prenatal visits as appropriate  
• Necessary supplies and material  
• Post-delivery exam  
• Post-natal visits  
• Lab services                                                                                       |
| Alternative birthing center (post-natal)                              | 2 post-natal visits within six weeks of the delivery                                                                                                       |
| Emergency room services                                               | $3 per visit for an emergency; lesser of 5% coinsurance or $6 per visit will be imposed if the condition is not an emergency                              |
| Urgent care center services                                           | $0 per visit                                                                                                                                               |
| Emergency ambulance and air transportation                            | • $0 per service  
• Basic life support (BLS) and advanced life support (ALS) ambulance services                                                                      |
<p>| Non-emergency ambulance stretcher services                            | Covered when other means of transportation could endanger the member’s health                                                                           |</p>
<table>
<thead>
<tr>
<th>Service</th>
<th>Cost-sharing and Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Emergency Transportation (NET)</td>
<td>Not covered by WellCare; this service is covered by KY Medicaid FFS</td>
</tr>
<tr>
<td>Meals and lodging</td>
<td>Covered for appropriate escorts of members to obtain covered medical services</td>
</tr>
<tr>
<td>Laboratory services</td>
<td>$0 per visit</td>
</tr>
<tr>
<td>Radiology services</td>
<td>$0 per visit</td>
</tr>
<tr>
<td>Physician services (PCPs), specialist, physician assistants, nurse practitioners, nurse midwives)</td>
<td>$0 per visit; covered services include office visits, medical and surgical care and consultation, diagnosis and treatment</td>
</tr>
<tr>
<td>Rural health clinic (RHC), federally qualified health center (FQHC) &amp; primary care center (PCC)</td>
<td>$2 per visit</td>
</tr>
<tr>
<td>Specialized children’s services clinics</td>
<td>$0 per visit; a child sexual abuse medical exam is covered if medically necessary and provided to a recipient who is under the age of 18 years</td>
</tr>
<tr>
<td>Second opinion</td>
<td>$0 per visit</td>
</tr>
<tr>
<td>Tele-health</td>
<td>$0 per service; the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance</td>
</tr>
<tr>
<td>Allergy services</td>
<td>$0 per visit; shots and allergy treatments limited to children under 21</td>
</tr>
<tr>
<td>Podiatry services</td>
<td>$0 per visit</td>
</tr>
<tr>
<td>Podiatry routine foot care</td>
<td>Not covered except for certain conditions that require professional supervision</td>
</tr>
<tr>
<td>Service</td>
<td>Cost-sharing and Details</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Maternity services</td>
<td>$0 per visit</td>
</tr>
<tr>
<td>Maternity service ultrasounds</td>
<td>2 per 9-month period unless more are needed</td>
</tr>
<tr>
<td>Oral and maxillofacial surgery (OMS)</td>
<td>$2 per visit; to correct diseases, injuries and defects in the head, neck, face, jaws and the hard and soft tissues of the mouth, jaws, face, skull, as well as associated structures</td>
</tr>
<tr>
<td>Chiropractic services</td>
<td>$2 per visit</td>
</tr>
<tr>
<td>Physical therapy</td>
<td>$2 per visit</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>$2 per visit</td>
</tr>
<tr>
<td>Speech therapy</td>
<td>$1 per visit</td>
</tr>
<tr>
<td>Behavioral health services</td>
<td>$0 per visit; includes mental health rehab/stabilization, behavioral support and psychological services</td>
</tr>
<tr>
<td>Targeted case management services</td>
<td>A minimum of four sessions in one month, including: 1 face-to-face contact with the recipient; 1 face-to-face contact with a parent, family member, guardian or other person who has custodial control or supervision of the recipient; and 2 additional contacts which may be by telephone or face-to-face</td>
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<tr>
<td>After school/summer program service</td>
<td>Rehabilitative and therapeutic activities that focus on the development of appropriate behaviors and social skills</td>
</tr>
<tr>
<td>Intensive outpatient behavioral health services</td>
<td>A structured program of individual and group therapeutic activities</td>
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<tr>
<td>Service</td>
<td>Cost-sharing and Details</td>
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</tr>
<tr>
<td>Therapeutic foster care service</td>
<td>Services in a therapeutic environment with 24-hour supervision and treatment in a family home by a therapeutic foster parent</td>
</tr>
<tr>
<td>Therapeutic group residential service</td>
<td>Services in a therapeutic environment with 24-hour supervision and treatment in a group residential facility</td>
</tr>
<tr>
<td>Crisis-stabilization service</td>
<td>Up to 10 consecutive days in a therapeutic environment that provides for the comprehensive assessment, diagnosis and treatment of complex behavioral health needs</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>Individual, family and group psychotherapy sessions</td>
</tr>
<tr>
<td>Substance Abuse Services</td>
<td>$0 per visit; limited to pregnant women and members less than 21 years old</td>
</tr>
<tr>
<td>Tobacco cessation</td>
<td>$0 per visit; 2 face-to-face assessments per calendar year; $0 per prescription for medication</td>
</tr>
<tr>
<td>Preventive care</td>
<td>Co-pays are $0 unless otherwise noted</td>
</tr>
</tbody>
</table>
| Health check services (EPSDT) for children younger than 21 | - Birth to 2 years: 1 exam at birth (neonatal examination) then at 1, 2, 4, 6, 9, 12, 15, 18 and 24 months of age  
- 3 years to 20 years: 1 exam each year for children ages 3–20                                       |
<p>| Cervical and vaginal cancer screening (Pap tests; pelvic exams) | 1 procedure per member, per year unless more are needed                                                                                                   |
| HIV Screening                                  | Covered for people who are pregnant or at increased risk for the infection, including anyone who asks for the test                                      |</p>
<table>
<thead>
<tr>
<th>Service</th>
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<tbody>
<tr>
<td>Immunizations</td>
<td>Includes immunizations and vaccines for children and vaccines for flu, pneumonia and hepatitis B; $0 co-pay</td>
</tr>
<tr>
<td>Nutritional counseling</td>
<td>To promote health and reduce risk associated with dietary factors</td>
</tr>
<tr>
<td>Dialysis End Stage Renal Disease (ESRD)</td>
<td>Services and procedures designed to promote and maintain the functioning of the kidney and related organs</td>
</tr>
<tr>
<td>Home health care services</td>
<td>$0 per visit; includes skilled nursing services, home health aide services, physical, speech and occupational therapy services; limited to 25 visits per calendar year</td>
</tr>
<tr>
<td>Durable medical equipment (DME)</td>
<td>3% coinsurance up to a maximum of $15 per month</td>
</tr>
<tr>
<td>Prosthetic &amp; orthotic devices</td>
<td>$0 per visit</td>
</tr>
<tr>
<td>Family planning</td>
<td>Available to all persons of child-bearing age; provided through routine physician visits or through family planning clinics</td>
</tr>
</tbody>
</table>
| Dental services for children younger than 21 | • $0 per visit  
• 1 oral exam per 12-month period  
• 2 cleanings per 12-month period  
• 1 set of X-rays per 12-month period  
• As required: extractions, fillings and emergency services and other dental services |
<table>
<thead>
<tr>
<th>Service</th>
<th>Cost-sharing and Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dental services for adults 21 and older</strong></td>
<td>• $0 per visit</td>
</tr>
<tr>
<td></td>
<td>• 1 dental visit per month per provider</td>
</tr>
<tr>
<td></td>
<td>• 1 oral exam per 12-month period</td>
</tr>
<tr>
<td></td>
<td>• 1 cleaning per 12-month period</td>
</tr>
<tr>
<td></td>
<td>• 1 set of X-rays per 12-month period</td>
</tr>
<tr>
<td></td>
<td>• Extractions and fillings</td>
</tr>
<tr>
<td><strong>Hearing services for children under 21</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Co-pays are $0</td>
</tr>
<tr>
<td><strong>Hearing aid/instrument services for children under 21</strong></td>
<td>• Includes assessment for hearing aid, fitting, orientation and repair</td>
</tr>
<tr>
<td></td>
<td>• Not to exceed $800 per ear every 36 months</td>
</tr>
<tr>
<td></td>
<td>• 1 audiologist visit per calendar year</td>
</tr>
<tr>
<td><strong>Vision services for children younger than 21</strong></td>
<td>• $0 co-pay per visit</td>
</tr>
<tr>
<td></td>
<td>• 1 exam per calendar year</td>
</tr>
<tr>
<td></td>
<td>• $200 limit per year for eyeglasses</td>
</tr>
<tr>
<td><strong>Vision services for adults older than 21</strong></td>
<td>• $0 per visit</td>
</tr>
<tr>
<td></td>
<td>• 1 eye exam per calendar year</td>
</tr>
<tr>
<td><strong>Prescription Drugs for members without Medicare Part D</strong></td>
<td>• $0 co-pay for generic</td>
</tr>
<tr>
<td></td>
<td>• $2 co-pay for brand</td>
</tr>
<tr>
<td><strong>Pharmacy maximum out of pocket (MOOP)</strong></td>
<td>Maximum out of pocket (MOOP) is $225 per calendar year but not more than 5% of a family’s income per quarter</td>
</tr>
</tbody>
</table>
The services listed below are not covered by Global Choices:

- Any laboratory service performed by a provider without current certification in accordance with the Clinical Laboratory Improvement Amendment (CLIA). This requirement applies to all facilities and individual providers of any laboratory service.
- Cosmetic procedures or services performed solely to improve appearance.
- Hysterectomy procedures, if performed for hygienic reasons or for sterilization only.
- Medical or surgical treatment of infertility (e.g., the reversal of sterilization, in vitro fertilization, etc.).
- Induced abortion and miscarriage performed out of compliance with federal and Kentucky laws and judicial opinions.
- Paternity testing.
- Personal service or comfort items.
- Post-mortem services.
- Services, including but not limited to drugs that are investigational, mainly for research purposes or experimental in nature.
- Sex transformation services.
- Sterilization of a mentally incompetent or institutionalized member.
- Services provided in countries other than the United States, unless approved by the Secretary of the Kentucky Cabinet for Health and Family Services.
- Services or supplies in excess of limitations or maximums set forth in federal or state laws, judicial opinions and Kentucky Medicaid program regulations referenced herein.
- Services for which the member has no obligation to pay and for which no other person has a legal obligation to pay are excluded from coverage.
- Services for substance abuse diagnoses in adults except for pregnant women, or in cases where acute care physical health services related to substance abuse or detoxification are necessarily required.
COVERED SERVICES FAMILY CHOICES

Family Choices is the Kentucky Medicaid benefit plan for most children. This plan covers basic medical services. Kentucky Children’s Health Insurance Program (KCHIP) is part of the Family Choices Plan. This is not a complete list of services. If a service is not listed, there is no co-pay. Some benefit limits can be increased if the service is medically necessary (requires prior approval).

Contact Customer Service with questions you may have about what services are covered. Call 1-877-389-9457 (TTY 1-877-247-6272).

<table>
<thead>
<tr>
<th>Service</th>
<th>Details and cost-sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-pay exempt members</td>
<td>Non-KCHIP children, children under 19 years of age who are in foster care, pregnant women, hospice care members and members in personal care or family care homes</td>
</tr>
<tr>
<td>Medical maximum out of pocket (MOOP)</td>
<td>Maximum out of pocket (MOOP) is $225 per calendar year but not more than 5% of a family’s income per quarter</td>
</tr>
<tr>
<td>Acute admissions medical diagnoses</td>
<td>$0 per admission</td>
</tr>
<tr>
<td>Mental health admissions mental health</td>
<td>$0 per admission</td>
</tr>
<tr>
<td>Acute health care related to substance abuse and/or for detoxification</td>
<td>$0 per admission</td>
</tr>
<tr>
<td>Nursing facility services</td>
<td>$0 per visit facility; physician services at a nursing facility are covered</td>
</tr>
<tr>
<td>Community mental health center (CMHC) services</td>
<td>$0 per admission; inpatient therapeutic program for persons who require less than 24-hour-a-day care but more than outpatient counseling</td>
</tr>
<tr>
<td>Service</td>
<td>Details and cost-sharing</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Psychiatric residential treatment facilities</td>
<td>$0 per visit; for members ages 6 to 21 who need continuous treatment and a more highly structured environment than they can receive in family and other community-based alternatives to hospitalization</td>
</tr>
<tr>
<td>Transplant services</td>
<td>$0 per transplant service</td>
</tr>
<tr>
<td>Outpatient hospital</td>
<td>$0 per visit</td>
</tr>
<tr>
<td>Ambulatory surgery center (ASC)</td>
<td>$0 per visit</td>
</tr>
</tbody>
</table>
| Alternative birthing center                     | • $0 per visit  
• Prenatal visits as appropriate  
• Necessary supplies and material  
• Post-delivery exam  
• Post-natal visits  
• Lab services                                                                                     |
| Alternative birthing center (post-natal)        | 2 post-natal visits within six weeks of the delivery                                                                                                     |
| Emergency room services                          | $0 per visit if emergent; lesser of 5% coinsurance or $6 per visit will be imposed if the condition is not an emergency                                      |
| Urgent care center services                      | $0 per visit for urgent illness or injury when the PCP office isn’t open or cannot be reached                                                          |
| Emergency ambulance and air transportation       | • $0 per service  
• Basic life support (BLS) and advanced life support (ALS) ambulance services                                                                     |
<p>| Non-emergency ambulance stretcher services       | Covered when other means of transportation could endanger the member’s health                                                                         |</p>
<table>
<thead>
<tr>
<th>Service</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Non-Emergency Transportation (NET)</td>
<td>Not covered by WellCare; this service is covered by KY Medicaid FFS</td>
</tr>
<tr>
<td>Meals and lodging</td>
<td>Covered for appropriate escorts of members to obtain covered medical services</td>
</tr>
<tr>
<td>Laboratory services</td>
<td>$0 per visit</td>
</tr>
<tr>
<td>Radiology services</td>
<td>$0 per visit</td>
</tr>
<tr>
<td>Physician services</td>
<td>$0 per visit; includes office visits, medical and surgical care and consultation, diagnosis and treatment</td>
</tr>
<tr>
<td>Rural health clinic (RHC), federally qualified health center (FQHC) &amp; primary care center (PCC)</td>
<td>$0 per visit</td>
</tr>
<tr>
<td>Specialized children’s services clinics</td>
<td>$0 per visit; a child sexual abuse medical exam is covered if medically necessary and provided to a recipient who is under the age of 18 years</td>
</tr>
<tr>
<td>Second opinion</td>
<td>$0 per visit</td>
</tr>
<tr>
<td>Tele-health</td>
<td>$0 per service; the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance</td>
</tr>
<tr>
<td>Allergy services</td>
<td>$0 per visit; shots and allergy treatments limited to children under 21</td>
</tr>
<tr>
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</tr>
<tr>
<td>Podiatry services</td>
<td>$0 per visit</td>
</tr>
<tr>
<td>Podiatry routine foot care</td>
<td>Not covered except for certain conditions that require professional supervision</td>
</tr>
<tr>
<td>Maternity services</td>
<td>$0 per visit</td>
</tr>
<tr>
<td>Maternity services ultrasounds</td>
<td>2 per 9-month period unless more are needed</td>
</tr>
<tr>
<td>Oral and maxillofacial surgery (OMS)</td>
<td>$0 per visit; to correct diseases, injuries and defects in the head, neck, face, jaws and the hard and soft tissues of the mouth, jaws, face, skull, as well as associated structures</td>
</tr>
<tr>
<td>Chiropractic services</td>
<td>$0 per visit</td>
</tr>
<tr>
<td>Physical therapy</td>
<td>$0 per visit</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>$0 per visit</td>
</tr>
<tr>
<td>Speech therapy</td>
<td>$0 per visit</td>
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<tr>
<td>Behavioral health services</td>
<td>$0 per visit; includes mental health rehab/stabilization, behavioral support and psychological services</td>
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<tr>
<td>Targeted case management services</td>
<td>A minimum of four sessions in one month, including: 1 face-to-face contact with the recipient; 1 face-to-face contact with a parent, family member, guardian or other person who has custodial control or supervision of the recipient; and 2 additional contacts which may be by telephone or face-to-face</td>
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<td>Intensive outpatient behavioral health services</td>
<td>A structured program of individual and group therapeutic activities</td>
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<tr>
<td>Therapeutic group residential service</td>
<td>Services in a therapeutic environment with 24-hour supervision and treatment in a group residential facility</td>
</tr>
<tr>
<td>Crisis-stabilization service</td>
<td>Up to 10 consecutive days in a therapeutic environment that provides for the comprehensive assessment, diagnosis and treatment of complex behavioral health needs</td>
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<tr>
<td>Psychotherapy</td>
<td>Individual, family and group psychotherapy sessions</td>
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<tr>
<td>After school/summer program service</td>
<td>Rehabilitative and therapeutic activities that focus on the development of appropriate behaviors and social skills</td>
</tr>
</tbody>
</table>
| Substance abuse services            | • $0 per visit  
• Limited to pregnant women and members less than 21 years old |
| Tobacco cessation                   | $0 per visit; 2 face-to-face assessments per calendar year; $0 per prescription for medication |
| Preventive care                     | Co-pays are $0 unless otherwise noted                                                   |
| Health check services (EPSDT)       | • Birth to 2 years: 1 exam at birth (neonatal examination) then at 1, 2, 4, 6, 9, 12, 15, 18 and 24 months of age  
• 3 years to 20 years: 1 exam each year for children ages 3–20 |
<p>| Cervical and vaginal cancer screening (Pap tests, pelvic exams) | 1 exam per calendar year unless medical documentation justifies additional services |
| HIV screening                       | Covered for people who are pregnant or at increased risk for the infection, including anyone who asks for the test |
| Immunizations                       | Includes immunizations and vaccines for children and vaccines for flu, pneumonia and hepatitis B |</p>
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<td>Services and procedures designed to promote and maintain the functioning of the kidney and related organs</td>
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<tr>
<td>Home health care services</td>
<td>$0 per visit; includes skilled nursing services, home health aide services, physical, speech and occupational therapy services; limited to 25 visits per calendar year</td>
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<tr>
<td>Durable medical equipment (DME)</td>
<td>$0 per item</td>
</tr>
<tr>
<td>Prosthetic &amp; orthotic devices</td>
<td>$0 per visit</td>
</tr>
<tr>
<td>Family planning</td>
<td>Available to all persons of child-bearing age; provided through routine physician visits or through family planning clinics</td>
</tr>
<tr>
<td>Dental services</td>
<td>$0 per visit; services include but not limited to exams, cleanings, X-rays, fillings, extractions, oral surgery and emergency dental treatment</td>
</tr>
<tr>
<td>Hearing service for children under 21</td>
<td>Co-pays are $0</td>
</tr>
<tr>
<td>Hearing aid/instrument services for children under 21</td>
<td></td>
</tr>
</tbody>
</table>
  - Includes assessment for hearing aid, fitting, orientation and repair  
  - Not to exceed $800 per ear every 36 months  
  - 1 audiologist visit per calendar year |
| Vision services                              |  
  - $0 per visit (children younger than 21)  
  - 1 eye exam per calendar year  
  - $400 limit per year for eyeglasses |
### Service Details and cost-sharing

<table>
<thead>
<tr>
<th>Service</th>
<th>Details and cost-sharing</th>
</tr>
</thead>
</table>
| Prescription Drugs for members without Medicare Part D                | • Unlimited  
• $0 co-pay for generic  
• $2 co-pay for brand                                                                     |
| Pharmacy maximum out of pocket (MOOP)                                  | Maximum out of pocket (MOOP) is $225 per calendar year but not more than 5% of a family's income per quarter |

The services listed below are not covered by Family Choices:

- Any laboratory service performed by a provider without current certification in accordance with the Clinical Laboratory Improvement Amendment (CLIA). This requirement applies to all facilities and individual providers of any laboratory service
- Cosmetic procedures or services performed solely to improve appearance
- Hysterectomy procedures, if performed for hygienic reasons or for sterilization only
- Medical or surgical treatment of infertility (e.g., the reversal of sterilization, in vitro fertilization, etc.)
- Induced abortion and miscarriage performed out of compliance with federal and Kentucky laws and judicial opinions
- Paternity testing
- Personal service or comfort items
- Post mortem services
- Services, including but not limited to drugs that are investigational, mainly for research purposes or experimental in nature
- Sex transformation services
- Sterilization of a mentally incompetent or institutionalized member
- Services provided in countries other than the United States, unless approved by the Secretary of the Kentucky Cabinet for Health and Family Services
- Services or supplies in excess of limitations or maximums set forth in federal or state laws, judicial opinions and Kentucky Medicaid program regulations referenced herein
Welcome to WellCare.

- Services for which the Member has no obligation to pay and for which no other person has a legal obligation to pay are excluded from coverage.
- Services for substance abuse diagnoses in adults except for pregnant women, or in cases where acute care physical health services related to substance abuse or detoxification are necessarily required.

Extra Benefits — WellCare offers extra benefits in addition to the standard benefits that you get as a Medicaid member. These include:

- $0 co-pay for doctor visits — Members pay $0 dollars to see their primary care provider or specialist.
- $0 co-pay for lab and radiology services.
- $0 co-pay for urgent care services.
- Free oral exams and cleanings every 12 months for members age 21 and older, with no co-pay.
- Free X-rays — X-ray for members age 21 and older, with no co-pay.
- Free eye exam — One per calendar year for members ages 21 and older, with no co-pay.
- No co-pay $0 for generic drugs — Members pay $0 for generic drugs on the plan’s preferred drug listing.
- No co-pay $0 for tobacco cessation office visits — Members pay $0 for office visits for tobacco cessation.
- Personal Care Items (OTC) — 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 listing that was included in your new-member packet. Make your selection and then call toll-free 1-877-389-9457. (TTY 1-877-247-6272) to place your order. Your items will be mailed to your home. You can check our website for the most updated version of this listing.
- Unlimited prescription drugs
- Free flu shots
- 24-hour Nurse Advice Line — Our Nurse Advice Line is available to you at no cost. You can call the line 24 hours a day, 7 days a week, every day of the year. The number is 1-800-919-8807.
Prenatal Rewards for Pregnant Women

• Free baby showers for pregnant women. Moms meet at a local venue to get gift baskets and tips about keeping mom and baby healthy.

• Free baby stroller. Just go to all your doctor visits during and after pregnancy. You then get a free baby stroller.

• Free maternity education booklet. Tips to help you stay well while you are pregnant.

Case/Disease Management

• Free 24-hour, 7-day-a-week health advice when you call your Personal Health Advisor.

• Free Care Guides — Booklets detailing how to care for diseases like asthma and diabetes.

• Free Disease/Case Management Programs — Programs are tracked and monitored by the member’s care coordinator or disease manager and include:

  - Respite Care — In-home and out-of-home services for family members who are caring for eligible ABD members. Respite care is short-term based care. It provides relief to caregivers. It may be provided hourly, daily and overnight. Respite care services are authorized by the member’s PCP as part of the member’s care plan. Respite care may be provided in the following locations:
    ◦ Member’s home
    ◦ Foster home or expanded-care adult residential care home
    ◦ Medicaid-certified nursing facility
    ◦ Licensed respite day care facility
    ◦ Other community care residential facilities approved by the plan

  - Quality Reward Program — Members can earn a free gift card for getting preventive care and taking care of themselves and their family
PRESCRIPTION DRUG SERVICES

How do I get a prescription?
Prescriptions must be written by a plan doctor.

Which drug stores will fill my prescription?
Prescriptions must be filled at a drug store in our network. A list of these drug stores is in your provider directory and at kentucky.wellcare.com.

How do I get a prescription filled?
Show your ID card when you give your prescription to the pharmacist.

What medicines does WellCare pay for?
WellCare pays for medicines on our Preferred Drug List (PDL). Doctors and pharmacists make the list. Your PCP will use the list when prescribing drugs for you. (Some drugs will require approval through a Coverage Determination Request (CDR) made by your doctor.) The list will also have drugs that may have limits such as prior authorization, quantity limits, step therapy, age limits or gender limits. If you would like to see the list, it is on our website. Go to kentucky.wellcare.com. You can also call and ask Customer Service to mail a printed list to you.

Are there medicines WellCare won’t pay for?
The plan does not pay for these medicines:
- Those used to help you get pregnant
- Those used for anorexia or weight gain
- Those used for erectile dysfunction
- Those that are used for cosmetic purposes or to help you grow hair
- Vitamins, except for prenatal vitamins and those listed on the PDL
- DESI (Drug Efficacy Study Implementation) drugs and drugs that are identical, related or similar to such drugs
- Investigational or experimental drugs

Can I get any medicine I want?
You will get all medicines that are covered and medically necessary. All drugs your providers order for you may be covered if they are on the Preferred Drug List (see above). 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 don’t try the alternative drug first.
Are generic drugs as good as brand-name drugs?
Yes. Generic drugs work the same as brand-name drugs. They have the same active ingredients as brand-name drugs.

OVER-THE-COUNTER (OTC) DRUGS

Does WellCare pay for Over-the-Counter (OTC) drugs?
WellCare pays for some OTC drugs. All OTC drugs covered on our plan require a prescription. We pay for these items:

• Antacids
• Aspirin
• Diphenhydramine
• H-2 receptor antagonist (a type of drug that reduces stomach acid)
• Ibuprofen
• Insulin
• Insulin syringes
• Meclizine (a type of drug that helps nausea and dizziness)
• Multivitamins/multivitamins with iron
• Non-sedating antihistamines
• Topical antifungals
• Urine test strips
ACCESS TO COVERED SERVICES

We have guidelines to ensure that our members can get to services in a timely manner.

You should be able to reach providers within the travel times shown below:

<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>IF YOU LIVE IN AN URBAN AREA</th>
<th>IF YOU LIVE IN A RURAL AREA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Providers (PCPs)</td>
<td>Within 30 minutes of driving time or 30 miles</td>
<td>Within 45 minute of driving time or 45 miles</td>
</tr>
<tr>
<td>Hospital care</td>
<td>Within 30 minutes of driving time</td>
<td>Within 60 minutes of driving time</td>
</tr>
<tr>
<td>Behavioral health services</td>
<td>Within 60 minutes of driving time</td>
<td>Within 60 minutes of driving time</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>Within 60 minutes of driving time or 50 miles</td>
<td>Within 60 minutes of driving time or 50 miles</td>
</tr>
<tr>
<td>Vision, lab and radiology services</td>
<td>Within 60 minutes of driving time</td>
<td>Within 60 minutes of driving time</td>
</tr>
<tr>
<td>Dental services</td>
<td>Within 60 minutes of driving time</td>
<td>Within 60 minutes of driving time</td>
</tr>
</tbody>
</table>

We also want you to be able to get these medical services within a reasonable amount of time:

- PCP appointments within 30 days of your request for routine visits
- Urgent care service within 48 hours
- Routine dental appointments within three weeks and urgent dental care within 48 hours
- Vision, lab and radiology appointments within 30 days for routine care and 48 hours for urgent care
NON-EMERGENCY MEDICAL TRANSPORTATION
Kentucky Medicaid provides non-emergency transportation services to some members. For more information about transportation services, call 1-888-941-7433.

CASE MANAGEMENT AND DISEASE MANAGEMENT PROGRAMS
Case and disease management services are available to members at no extra cost. Our Case Management Program offers members help with special health situations. Some — but not all — of the services include help with these issues:

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

Our Disease Management Program supports members with the following conditions:

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

You can find out more or enroll in these services by calling 1-877-389-9457 (TTY 1-877-247-6272). Call Monday–Friday, 8 a.m. to 5 p.m. Eastern.

Behavioral Health Crisis Hotline: 1-855-661-6973

There are other programs to help you with your health care needs:
Welcome to WellCare. Weight management — At WellCare we want to help you. If you’re ready to lose weight and would like more information on nutrition and a healthy diet, you can begin by contacting the audio health library at our Nurse Advice Line. Call 1-800-919-8807.

Smoking cessation — You’re eligible for a program to help you quit smoking. You can contact us for more information about resources such as talking with a nurse, quit-line counseling and medication by calling 1-877-389-9457 (TTY 1-877-247-6272). Call Monday–Friday, 7 a.m. to 7 p.m. Eastern.

Behavioral health crisis hotline — We have a behavioral health hotline available to you if you need to talk with someone. The hotline is available to you 24 hours a day, seven days a week. Just call 1-855-661-6973.

Customer Service can answer questions you might have about these programs. Just call 1-877-389-9457 (TTY 1-877-247-6272). Call Monday–Friday, 7 a.m. to 7 p.m. Eastern.

You can find out more or enroll in these services by calling 1-877-389-9457 (TTY 1-877-247-6272). Call Monday–Friday, 7 a.m. to 7 p.m. Eastern.

HELP FROM YOUR SERVICE COORDINATOR
Members in our Case Management or Disease Management programs with medical and/or behavioral health coordination needs may be assigned to a Service Coordinator. He or she can help you:

• Arrange transportation services to your doctors
• Find a provider
• Coordinate care with the doctors
• Find answers to your questions about things like your benefits, medical care or medicines

You can ask to change your Service Coordinator. Just call Customer Service at the phone number listed below. You can also send a written request. There also may be times when we may need to change your Service Coordinator. Your new Service Coordinator will call you and tell you why the change was made.

You can call your Service Coordinator anytime you need to during business hours and leave him or her a message. Your Service Coordinator will return your call within three days.
You will get contact information so you can reach your Service Coordinator. You will get details about your face-to-face visit as well. You can also write down this information here:

My Service Coordinator’s Name: ____________________________________________
Phone Number: __________________________________________________________

BEHAVIORAL HEALTH SERVICES
We can help you get a mental health or substance abuse assessment if you are an eligible member. Call Customer Service to find out more. Our staff will be happy to help you.

You do not need prior approval from your PCP.

We will give you names of providers near you. You may choose from these names to set an appointment.

What to do if you are having a problem
You should call us if you are having any of these problems:

- Always feeling sad
- Problems with drugs or alcohol
- Feeling hopeless and/or helpless
- Feelings of guilt and/or worthlessness
- Difficulty sleeping
- Poor appetite
- Weight loss
- Loss of interest
- Difficulty concentrating
- Irritability
- Constant pain such as headaches, stomach and backaches

You do not need to call your PCP for a referral. You will get an approval for services when you call us. If you use a provider without getting approval from us, you may have to pay the bill.

What to do in a behavioral health emergency
First, decide if it is a true behavioral health emergency. Do you think that you are a
danger to yourself or others? If so, call 911 or go the nearest emergency room. Do this even if the emergency room is not in our service area.

If you need emergency behavioral health care outside our service area, please tell us. Just call the number on your ID card. You should also call your PCP if you can. Call your PCP again in 24 to 48 hours. Once you are stable, plans will be made to transfer you to an in-network facility.

You can also call the crisis hotline number on the number on your ID card.

**Behavioral health limitations and exclusions**

We will not cover services if they’re not medically necessary.

**OTHER PROGRAMS**

WellCare also offers the services listed below in your area. Call your PCP or Customer Service to learn more.

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

WellCare also publishes a newsletter that you’ll receive by mail. It has useful member information, tips for using your benefits and articles on fitness and health education.

**FAMILY PLANNING**

You can get the following family planning services:

- Advice for birth control
- Pregnancy tests,
- Sterilization
- A medically necessary abortion.

During your visits for these things, you can also get tests for:

- Sexually transmitted infections,
- A breast cancer exam,
- A pelvic exam.
You do not need a referral from your PCP to get these services. In fact, you can choose where to get these services. You can use your WellCare ID card to see one of WellCare’s family planning providers. Check the plan’s Provider Directory or call Customer Service for help in finding a provider. Ask your PCP or call Customer Service at 1-877-389-9457 (TTY 1-877-247-6272).

**HIV COUNSELING AND TESTING**
You can get HIV testing and counseling any time you have family planning services. You do not need a referral from your PCP (primary care provider). Just make an appointment with one of our family planning providers.

**HOW TO GET SERVICES**

**SERVICES THAT REQUIRE A REFERRAL**
Your PCP will need to make a referral for you to get certain services. These include:
- Services that your PCP doesn’t perform
- Specialist visits at an office or free-standing clinic

**SERVICES AVAILABLE WITHOUT A REFERRAL (SELF-REFERRAL SERVICES)**
You don’t need approval from your PCP or the plan for these services:
- Emergency and urgent care services
- Well-child treatment visits for children up until their 21st birthday
- Annual wellness visit for women, including a Pap smear
- Routine vision provided by WellCare vision providers

You can go to any WellCare provider to get the services listed above. Just call the provider you choose and make an appointment. Tell them that you are a WellCare member and show them your ID card at your visit.

Medical tests and treatments must be ordered by your PCP or another doctor your PCP has recommended. Your doctor can refer you to these services without asking WellCare for an authorization as long as they are medically necessary and ordered by a doctor:
- Routine diagnostic tests
• Lab tests
• Basic radiology services
• Some routine office-based procedures (not in a hospital)

You can find a list of providers on the Web. Just visit kentucky.wellcare.com. You can also call Customer Service to ask for a directory.

SERVICES THAT REQUIRE PRIOR AUTHORIZATION
We need to approve the following services before you can get them. This is called prior authorization. Your PCP or specialist will contact us to ask for this approval. We'll notify you of our decision. If we don’t approve them, we will give you information about the grievance and appeals process and your right to a state hearing.

This list may change. You can go to kentucky.wellcare.com or call Customer Service for the most up-to-date list of services that require a prior authorization:

• Medical supplies and equipment that are rented or purchased for a cost of more than $500
• Certain medical tests done by your PCP or specialist
• Cardiac and pulmonary rehabilitation programs
• Home health care
• Therapies (physical, occupational, speech)
• Cosmetic procedures
• Investigational and experimental procedures and treatments

We’ll make a decision for a regular service request within two business days of getting the request from your doctor. We or your doctor may need more time to make this decision. If so, we will make a decision within the next 14 days. For services that are needed urgently to avoid putting your life or health in danger, we will make a decision as quickly as possible, in no longer than two business days. These decisions usually happen within one day.

UTILIZATION MANAGEMENT PROGRAM
We have a utilization management (UM) program. This program looks at the care and services you need. We also look at services that need approval before they can be given. Then we check to see if this is the right care for you before it starts. We complete checks called:
• Preservice — before you get care we check to see if this is the best care for your health
• Concurrent reviews — we look at care while you are getting it to see if you need to keep getting it, and/or if other care would better meet your needs
• Retrospective reviews — we check to see if you needed the care you got, after you received it

We do these reviews to measure the health care and services you receive. We measure this based on your health plan coverage. We check to see if the care and services are provided at the right place and at the right time. Then we determine how much coverage we can provide according to your benefits. And we decide on how to pay those who provide the care.

For all of these types of reviews, there may be times when we say we are unable to cover services or care that your provider asks for. This may be due to benefit limitations or lack of medical necessity. These decisions may be made by our clinical staff of nurses and doctors.

We do not give a reward to anyone to encourage fewer services for members.

In a retrospective review, your provider will not bill you for covered services you have received that we determine were not medically necessary.

You may have questions or issues or want to learn more about the UM process. If so, Customer Service can help.

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 1-877-389-9457 (TTY 1-877-247-6272).

SECOND MEDICAL OPINION
Call your PCP to get a second opinion about your care. This includes second opinions about surgeries or complex procedures. Your PCP will ask you to pick a plan doctor in your area. If you can’t find another plan doctor in your area, your PCP will ask you to pick a doctor who is not in our network. Your PCP will get authorization for this visit. You don’t have to pay for these services. You can also call Customer Service to help you with getting a second opinion. If the second-opinion doctor asks for tests, they must be done by a plan provider.

Your PCP will look at the second opinion. He or she will then decide the best way to treat you. You must get approval to see an out-of-network doctor. Otherwise, you may have to pay for the doctor visit.

OUT-OF-NETWORK PROVIDER
“Out-of-network provider” means a provider who is not a participating provider and who provides a service with respect to a particular illness or injury. The referral to an out-of-network provider must be authorized in advance by WellCare. If WellCare is unable to provide necessary medical services, we shall timely and adequately cover these services out of network for the Member. WellCare would coordinate with out-of-network providers with respect to payment. WellCare will ensure that cost to the Member is no greater than it would be if the services were provided within the WellCare Network.

HOW TO GET AFTER-HOURS CARE
If you get sick or hurt when your PCP’s office is closed, and it is not an emergency, call your PCP. Your PCP’s office will direct you on how to get care. If you can’t reach your doctor, you can go to an urgent care center.

You can also call our 24-hour Nurse Advice Line at 1-800-919-8807. (See the Nurse Advice Line section on page 10.)

EMERGENCY SERVICES
Emergency services are for a condition that is very serious and must be treated right away. They may include inpatient and outpatient services.
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.

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)

Here are some examples of times when you would want to go to an emergency room and times when you would want to call your PCP or go to an urgent care center:

<table>
<thead>
<tr>
<th>Examples for visiting the ER</th>
<th>Examples for visiting your PCP or the urgent care center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of consciousness, fainting</td>
<td>Earache</td>
</tr>
<tr>
<td>Signs of heart attack or stroke</td>
<td>Small cuts</td>
</tr>
<tr>
<td>Severe shortness of breath</td>
<td>Dog bite</td>
</tr>
<tr>
<td>Bleeding severely or uncontrollably</td>
<td>Sprains and strains</td>
</tr>
<tr>
<td>Sudden, constant pain</td>
<td>Asthma (unless life-threatening)</td>
</tr>
<tr>
<td>Head or spinal injury</td>
<td>Low fever</td>
</tr>
<tr>
<td>Suicidal feelings</td>
<td>Coughs, colds, flu</td>
</tr>
<tr>
<td>Seizures</td>
<td>Eye problems (infections, scratches)</td>
</tr>
</tbody>
</table>
Welcome to WellCare.

Examples for visiting the ER | Examples for visiting your PCP or the urgent care center
--- | ---
Miscarriage or pregnancy with vaginal bleeding | Stomach ache
Physical attack or rape | Backache
Poisoning or drug overdose | Migraine
Severe vomiting or diarrhea that does not stop | Sore throat
Paralysis | Skin rash
Shock | Sexually Transmitted Diseases
Major burns | Medication review
Suddenly become confused – mental status changes | Physical exams
Any life-threatening situation | Immunizations

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.
Not sure whether it’s a true emergency? Call your PCP. And remember that the 24-hour Nurse Advice Line is always there to help at 1-800-919-8807!

Post-stabilization services
It’s important that you get care until your condition is stable. We’ll 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. If you are admitted to the hospital from the emergency room, tell the hospital to call WellCare and let us know you are there.

Out-of-area emergency care
What should you do if you have an emergency while traveling? Go to a hospital. Show your ID card. Call your PCP as soon as you can. Ask the hospital staff to call us. If you have to pay for care you get while you’re out of the service area, write to our claims department. They’ll need copies of your medical reports and the bills. They’ll also need proof of payment.

What should you do if you get sick or hurt while out of the WellCare service area and it is not an emergency? Call Customer Service.

Medical services for adults and children in a foreign country are not covered. You will need to pay for these services yourself.

WHAT TO DO IF YOU NEED URGENT CARE
You should still call your PCP first for all urgent care. Urgent care is needed when you require medical care within 24 hours, but the problem will not cause serious harm to your health. You may go to an urgent care center when your PCP cannot see you within 24 hours. Such conditions include:

- Injury
- Illness
- Severe pain

Not sure you need urgent care? Call your PCP. Urgent care center services do not need prior approval. You’ll need to show your WellCare and Medicaid ID cards at the urgent care center. Ask the staff to call us.

Let your PCP know if you get care in an urgent care center. That way, he or she can give you follow-up care.
OUT-OF-AREA COVERAGE
If you have an emergency while you’re out of the service area, go to a hospital. Show your ID card. Call your PCP as soon as you can. Ask the hospital staff to call WellCare. If you have to pay for care you get while you’re out of the service area, write to our Claims department. They will need copies of your medical reports and bills. They will also need proof of payment.

For services that are not emergencies, we cover any medically necessary services that are not available in the WellCare service area. If you need a service out of area, just contact us. We’ll work with you and your PCP to try to get the service locally. We will provide these services out of the area if needed.

This includes:
- Referrals to an out-of-area specialist or facility
- Transportation to and from the referral destination
- Lodging and meals for you and any needed attendant

If you get sick or hurt or need medically necessary services while you are out of the service area, and it isn’t an emergency, call Customer Service. Call toll-free 1-877-389-9457 (TTY 1-877-247-6272). We will help arrange the care you need and ensure you get approval before receiving services.

If you have an emergency out of the service area, go to a hospital. Show your ID card. Call your PCP as soon as you can. Ask the hospital staff to call WellCare. If you have to pay for care you get while you are out of the service area, write to our Claims department. They will need copies of your medical reports and the bills. They will also need proof of payment.

Medical services for adults and children in a foreign country are not covered. You will need to pay for these services yourself.

PREGNANCY AND NEWBORN CARE
We cover our members throughout their pregnancy and their newborn(s) after birth. Your baby will be automatically enrolled in WellCare. You can keep your baby in WellCare or choose another plan.

Moms-to-be should make plans to visit a WellCare OB (obstetrics) doctor within 14 days of signing up for the plan or finding out you’re pregnant. Customer Service can help you set an appointment.
There are more reasons you should call us. We can get you information about having and caring for a baby. We can sign you up for our prenatal programs. You will also need to choose a PCP for your baby. You should do this by the time the baby is born. If you do not choose, we will assign one.

LONG-TERM CARE SERVICES
Your WellCare plan may not pay for some long-term care services such as living in a Skilled Nursing Facility or providing assistance with your daily housekeeping and living activities. However, we can help you find the right Kentucky Medicaid program for your needs. A Wellcare service coordinator will assess your needs and help you decide on the program that is best for you. We will work with other Kentucky programs to make sure your care plan information is transferred to the new program and there is no break in your care. If you don’t have a service coordinator assigned to you already, you can call Customer Service and ask to be contacted by a service coordinator.

COMMUNITY-BASED SERVICES
Kentucky offers several programs that you and/or your child may qualify for. These programs are offered in the community through the Department of Community Based Services (DCBS). DCBS works closely with community organizations to make these programs available to you and your family. These programs include:

- Foster care
- Adoption
- Child care assistance
- Family supports like:
  - Supplemental Nutrition Assistance Program (SNAP) – food stamps
  - Kentucky Works programs (Works)
  - Family Alternatives Diversion Program (FAD)

You can apply for the programs and services above by calling or stopping by a local DCBS office. A local directory of DCBS offices is available by calling WellCare Customer Service.

Family Resource and Youth Services Centers
The Division of Family Resource and Youth Services Centers provides administrative support, technical assistance and training to local school-based Family Resource and Youth Services Centers (FRYSC). The primary goal of these
centers is to remove barriers to learning and enhance student success. Each center offers programs, services and resources to help children and families reach success.

Kentucky is divided into 11 districts:

<table>
<thead>
<tr>
<th>Office</th>
<th>Office County</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region 1</td>
<td>Murray</td>
<td>270-759-3164</td>
</tr>
<tr>
<td>Region 2</td>
<td>Morganfield</td>
<td>270-285-2553</td>
</tr>
<tr>
<td>Region 3</td>
<td>Louisville</td>
<td>502-595-4814</td>
</tr>
<tr>
<td>Region 4</td>
<td>Falmouth</td>
<td>859-654-3381</td>
</tr>
<tr>
<td>Region 5</td>
<td>Lexington</td>
<td>859-219-3159</td>
</tr>
<tr>
<td>Region 6</td>
<td>Richmond</td>
<td>859-200-7777</td>
</tr>
<tr>
<td>Region 7</td>
<td>Morehead</td>
<td>606-207-4287</td>
</tr>
<tr>
<td>Region 8</td>
<td>Jackson</td>
<td>606-272-0071</td>
</tr>
<tr>
<td>Region 9</td>
<td>Barbourville</td>
<td>606-545-2110</td>
</tr>
<tr>
<td>Region 10</td>
<td>Frankfort</td>
<td>502-564-4986</td>
</tr>
<tr>
<td>Region 11</td>
<td>Elizabethtown</td>
<td>270-505-6533</td>
</tr>
</tbody>
</table>

**CARE TO KEEP YOUR CHILD WELL (EPSDT)**

WellCare has an EPSDT program. It stands for “Early and Periodic Screening, Diagnosis and Treatment.” It provides needed care for children up to age 21. EPSDT care is done as part of a well-child checkup and may include services like:

- A comprehensive history and physical exam
- Behavioral and mental health assessment
- Growth and development chart
- Vision, hearing and language screening
- Nutritional health and education
- Lead risk assessment and testing, as appropriate
- Age-appropriate immunizations
- Dental screening and referral to dentist
- Referral to specialists and treatment, as appropriate
- Any needed services as part of a treatment plan that is approved as medically necessary by the plan
• Regular preventive dental and treatment services, including screening examinations, prophylactic treatment (scaling and polishing), following the Academy of Pediatric guidelines

With our EPSDT Program, children may be able to get added Medicaid services. To learn more, call Customer Service.

What is a well-child checkup?
A well-child checkup is when your child’s PCP will make sure that your child is growing up healthy. The PCP will:

• Do a comprehensive head-to-toe physical and behavioral health exam
• Give any needed shots
• Do any needed blood and urine tests
• Look into your child’s mouth and check teeth
• Test your child for tuberculosis and lead (when age appropriate)
• Give you health tips and education to help you help your child
• Talk to you about your child’s growth, development and eating habits
• Measure height, weight, blood pressure and how well your child sees and hears

There are certain services that your child should get at each age. These can be found in the Preventive Health Guidelines section of this book.

Why is the well-child checkup important?
Checkups help find health concerns before they become bigger problems. Also, your child can get the shots he or she needs during these visits.

When should a well-child checkup occur?
Your children should visit his or her PCP for these well-child checkups. He or she should go even when he or she is well, and go at these times, as recommended by the American Academy of Pediatrics:

- Newborn up to 5 days
- 1 Month
- 2 Months
- 4 Months
- 6 Months
- 9 Months
- 12 Months
- 15 Months
- 18 Months
- 24 Months
- 30 Months
- 3 Years
- 4 Years
- 5 Years
- 6 Years
- 7 Years
- 8 Years
- 9 Years
- 10 Years
- 11 Years
- 12 Years
How much does a well-child checkup cost me?
Nothing. Checkups are done by your child’s PCP at no cost to you.

What if I need help getting a doctor visit?
We can help you get an appointment. Just call Customer Service.

What if I need help getting to the doctor visit?
We can help you get a ride to the doctor. Call Customer Service.

PREVENTIVE HEALTH GUIDELINES

The next few pages of this book tell you when you and your family should get checkups, tests and shots.

You can use the guidelines to help you know when it is time to visit your PCP. They also tell you what services you should get from your PCP. Please look at these guidelines. If you see that you or anyone in your family is missing a checkup or test, you should call your doctor for an appointment.

We will help you remember to get these services. We will send each family member a reminder every year on his or her birthday. It will tell him or her about the tests and shots he or she may need.

These guidelines do not replace your PCP’s advice. When you see your PCP, he or she may tell you that other services are needed. This would be based on your specific health care needs. Always talk with your PCP. Be sure to tell him or her about your health concerns. This will help you and your family get the right care.

Remember — if you just joined the plan, it’s a good idea to see your PCP within 90 days.
### PREVENTIVE HEALTH GUIDELINES — NEWBORN UP TO 21 YEARS OLD

<table>
<thead>
<tr>
<th>Age</th>
<th>Checkup and shots for your child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn up to 5 days</td>
<td>Well-Child Checkup*, Hearing Screening, Hepatitis B (Hep B) Shot, Newborn Screening Blood Tests</td>
</tr>
<tr>
<td>1 Month</td>
<td>Well-Child Checkup*, HepB Shot (second dose between 1 and 2 months)</td>
</tr>
<tr>
<td>2 Months</td>
<td>Well-Child Checkup*, Shots: Diphtheria, Tetanus and Pertussis (DTaP), Polio (IPV), Pneumococcal (PCV), Haemophilus Influenzae Type B (Hib), Rotavirus (RV)</td>
</tr>
<tr>
<td>4 Months</td>
<td>Well-Child Checkup*, Shots: DTaP, IPV, PCV, Hib, RV</td>
</tr>
<tr>
<td>6 Months</td>
<td>Well-Child Checkup*, Shots: DTaP, IPV, PCV, Hib, RV-depending on brand used, HepB, Blood lead risk assessment, and Begin Yearly Flu Shot if fall or winter</td>
</tr>
<tr>
<td>9 Months</td>
<td>Well-Child Checkup*, Lead Screening</td>
</tr>
<tr>
<td>12 Months</td>
<td>Well-Child Checkup*, Shots: The following shots between 12 and 15 months are: PCV, Hib, Measles, Mumps and Rubella (MMR), Varicella (chicken pox VZV). Hepatitis A (HepA) 2 doses between 12 and 23 months). Dental Visit (as recommended by your doctor). Blood Lead Test, Yearly Flu shot if not done at 6 months.</td>
</tr>
<tr>
<td>15 Months</td>
<td>Well-Child Checkup*, Shot: DTaP (between 15 and 18 months)</td>
</tr>
<tr>
<td>18 Months</td>
<td>Well-Child Checkup*, HepA</td>
</tr>
<tr>
<td>24 Months</td>
<td>Well-Child Checkup*, Blood Lead Test, Dental Visit, and Yearly Flu Shot during fall or winter</td>
</tr>
<tr>
<td>30 Months</td>
<td>Well-Child Checkup*, Vision and Hearing Screenings</td>
</tr>
<tr>
<td>3 Years</td>
<td>Well-Child Checkup*, Eye screening, Dental Visit once a year, Yearly Flu Shot</td>
</tr>
<tr>
<td>Age</td>
<td>Checkup and shots for your child</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>4 Years</td>
<td>Well-Child Checkup*, Dental Visit once a year. Shots: Measles, Mumps and Rubella (MMR), Diphtheria, Tetanus and Pertussis (DTaP), Polio (IPV), Varicella (Chicken Pox VZV), Yearly Flu Shot</td>
</tr>
<tr>
<td>5 Years</td>
<td>Well-Child Checkup*, Dental Visit once a year, Eye screening and Urine test if needed. Catch up on all shots before Kindergarten, and Yearly Flu Shot</td>
</tr>
<tr>
<td>6 Years</td>
<td>Well-Child Checkup*, Dental Visit once a year, and Yearly Flu Shot</td>
</tr>
<tr>
<td>7 Years</td>
<td>Well-Child Checkup*, Dental Visit once a year, and Yearly Flu Shot</td>
</tr>
<tr>
<td>8 Years</td>
<td>Well-Child Checkup*, Dental Visit once a year, and Yearly Flu Shot</td>
</tr>
<tr>
<td>9 Years</td>
<td>Well-Child Checkup*, Dental Visit once a year, and Yearly Flu Shot</td>
</tr>
<tr>
<td>10 Years</td>
<td>Well-Child Checkup*, Dental Visit once a year, and Yearly Flu Shot</td>
</tr>
<tr>
<td>11 Years</td>
<td>Well-Child Checkup*, Dental Visit once a year. Shots: Tetanus, Diphtheria and Pertussis (Tdap), Meningococcal (MCV4), and Yearly Flu Shot</td>
</tr>
<tr>
<td>12 Years</td>
<td>Well-Child Checkup*, Dental Visit once a year. Shots: Tdap, MCV4, HPV (earliest age 9 years), Yearly Flu Shot and catch up on all shots needed before 7th grade</td>
</tr>
<tr>
<td>13 Years</td>
<td>Well-Adolescent Checkup*, Dental Visit once a year, Yearly Flu Shot, Urine Test as recommended. HPV series if not done previously. Yearly Female Pelvic exam, Pap smear, and Chlamydia screening if sexually active.</td>
</tr>
<tr>
<td>Age</td>
<td>Checkup and shots for your child</td>
</tr>
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<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>14 Years</td>
<td>Well-Adolescent Checkup*, Dental Visit once a year, Yearly Flu Shot</td>
</tr>
<tr>
<td>15 Years</td>
<td>Well-Adolescent Checkup*, Dental Visit once a year, Yearly Flu Shot</td>
</tr>
<tr>
<td>16 Years</td>
<td>Well-Adolescent Checkup*, Dental Visit once a year, Yearly Flu Shot, Booster Meningococcal (MCV4), Tdap as needed</td>
</tr>
<tr>
<td>17 Years</td>
<td>Well-Adolescent Checkup*, Dental Visit once a year, Yearly Flu Shot</td>
</tr>
<tr>
<td>18 Years</td>
<td>Well Checkup*, Dental Visit once a year, Yearly Flu Shot. Yearly Female Pelvic exam, Pap smear, and Chlamydia screening if sexually active</td>
</tr>
<tr>
<td>19 Years</td>
<td>Well Checkup*, Dental Visit once a year, Yearly Flu Shot. Yearly Female Pelvic exam, Pap smear, and Chlamydia screening if sexually active</td>
</tr>
<tr>
<td>20 Years</td>
<td>Well Checkup*, Dental Visit once a year, Yearly Flu Shot. Yearly Female Pelvic exam, Pap smear, and Chlamydia screening if sexually active</td>
</tr>
</tbody>
</table>

At each well checkup*, your child’s Primary Care Provider may perform the following:

- Physical exam: Unclothed and covered
- Vital signs: Temperature, pulse, blood pressure, height, weight, body mass index (BMI)
- Health history, developmental and behavioral health assessment
- Measuring the size of your baby’s head until age 2
- Health Education and counseling: Sleep position counseling for infants 0-9 months old, injury/violence prevention, nutritional and physical activity
- Blood work: Hemoglobin or hematocrit, tuberculosis (Tb)
- Heart disease assessment or cholesterol screening at age 2
• Catch-up on any shots that were previously missed
• Sexually transmitted infection (STI) testing and protection
• Screenings/Tests: Vision, hearing, lead, urine
• Referrals to specialists

For children/adolescents with asthma:
If your child has not seen their Primary Care Provider within the last 3 months, call and make an appointment for your child. Your child’s Primary Care Provider can work with you to help keep your child’s asthma under control and on track with their asthma action plan.

For children/adolescents with diabetes:
If your child has diabetes and has not seen their Primary Care Provider in the last 3 months, call and make an appointment for your child. This is very important.

National guidelines say that people with diabetes should have the following:
• Blood Sugar Average, called a hemoglobin A1c (HbA1c): should be checked at least twice a year (it should be less than 7%)
• LDL-cholesterol: Checked at least once a year (it should be less than 100mg/dL)
• A urine test for protein and microalbumin once a year
• Eye exam (dilated) by an eye doctor every year
• Routine foot exams
**ADULT PREVENTIVE HEALTH GUIDELINES & 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 30 days. Otherwise, adults should get checkups as show below, even if they don’t feel ill:

- Age 19 to 39 — every 1 to 3 years. (Women should get an annual Pap smear. If three normal smears in a row, then one every three years.)
- Age 40 to 64 — every 1 to 2 years based on risk factors.
- Age 65 and older — every year.

<table>
<thead>
<tr>
<th>Age</th>
<th>Screening and Immunization Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 to 39 years old</td>
<td>Blood Pressure, Height, Weight, Body Mass Index (BMI), Alcohol/Tobacco Use</td>
</tr>
<tr>
<td></td>
<td>Cholesterol check if you have risk factors like: diabetes, smoking, overweight, high blood pressure, or high cholesterol</td>
</tr>
<tr>
<td></td>
<td>Begin Routine Cholesterol check for males 35 and older</td>
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<tr>
<td></td>
<td>Pap Smear — Females</td>
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<tr>
<td></td>
<td>Mammogram Screening — If high risk or a baseline</td>
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<tr>
<td></td>
<td>Chlamydia Screening — Females</td>
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<tr>
<td></td>
<td>Tetanus and Diphtheria shot</td>
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<tr>
<td></td>
<td>Vision screening for glaucoma and diabetic retinal exam if risk factors like diabetes or high blood pressure</td>
</tr>
<tr>
<td></td>
<td>Pneumonia (PPSV) shot if you have risk factors like: smoking, diabetes, heart, liver, lung, or kidney disease</td>
</tr>
<tr>
<td>Age</td>
<td>Screening and Immunization Schedule</td>
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<tr>
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<td>-----------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>21 to 39 years old</td>
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<tr>
<td></td>
<td>Varicella (chickenpox VZV) shot If you have not had the chicken pox or if didn’t get this shot. Check with your doctor if you need a second dose</td>
</tr>
<tr>
<td>Age</td>
<td>Screening and Immunization Schedule</td>
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<tr>
<td>----------------------</td>
<td>------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>40 to 64 years old</td>
<td>Blood Pressure, Height, Weight, Body Mass Index (BMI), Alcohol/Tobacco Use At least once every 1–2 years</td>
</tr>
<tr>
<td></td>
<td>Cholesterol check if you have diabetes or other risk factors like: smoking, overweight, high blood pressure, or high cholesterol Every Year or as advised by your Primary Care Provider</td>
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<tr>
<td></td>
<td>Begin Routine Cholesterol check for males age 35 or females age 45 Every 5 years</td>
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<tr>
<td></td>
<td>Mammogram – Females begin at age 40 Every 1–2 years</td>
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<tr>
<td></td>
<td>Pap Smear and Chlamydia screening (female) Every 1–3 years or as recommended by Primary Care Provider</td>
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<tr>
<td></td>
<td>Osteoporosis Screening (Bone Density Test) Female at risk for fractures, begin at age 60 Every 2 years or as recommended by Primary Care Provider</td>
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<tr>
<td></td>
<td>Prostate Specific Antigen (PSA) and rectal exam – Males begin at age 40 As recommended by Primary Care Provider</td>
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<tr>
<td></td>
<td>Colorectal Cancer Screening – begin age 50 Every 2–10 years depending on your results and risk factors</td>
</tr>
<tr>
<td></td>
<td>Vision screening to check for eye diseases like glaucoma and diabetic retinopathy with risk factors like diabetes or high blood pressure Yearly or as recommended by an ophthalmologist or optometrist</td>
</tr>
<tr>
<td></td>
<td>Hearing screening – begin at age 50 Routine</td>
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<tr>
<td></td>
<td>Tetanus and Diphtheria shot Booster every 10 years</td>
</tr>
<tr>
<td></td>
<td>Flu shot Every year even if healthy</td>
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<tr>
<td></td>
<td>Pneumonia (PPSV) shot if you have risk factors like: smoking, diabetes, heart, liver, lung, or kidney disease 1 dose, may need an additional dose</td>
</tr>
<tr>
<td></td>
<td>Varicella (chickenpox VZV) shot If you have not had the chicken pox or did not get this shot; check with your Primary Care Provider if you need a second dose</td>
</tr>
<tr>
<td>Age</td>
<td>Screening and Immunization Schedule</td>
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</tr>
<tr>
<td>40 to 64 years old</td>
<td>Zoster (shingles) shot 1 dose starting at age 60</td>
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<tr>
<td></td>
<td>Measles, Mumps, Rubella (MMR) shot Adults born after 1957 should receive 1-2 doses if not already immune</td>
</tr>
<tr>
<td></td>
<td>Hepatitis A (Hep A) shot If you have not had this shot or if you may be in contact with international or people at risk</td>
</tr>
<tr>
<td></td>
<td>Hepatitis B (Hep B) shot Check with your Primary Care Provider if you already had this shot in the past</td>
</tr>
<tr>
<td>65 and Older</td>
<td>Blood Pressure, Height, Weight, Body Mass Index (BMI), Alcohol/Tobacco Use Yearly</td>
</tr>
<tr>
<td></td>
<td>Cholesterol check if you have diabetes or other risk factors like: smoking, overweight, high blood pressure, or high cholesterol Every Year or as advised by your Primary Care Provider</td>
</tr>
<tr>
<td></td>
<td>Routine Cholesterol check Every 5 years</td>
</tr>
<tr>
<td></td>
<td>Pap Smear and Chlamydia screening (female) As recommended by Primary Care Provider</td>
</tr>
<tr>
<td></td>
<td>Osteoporosis Screening (Bone Mass Density) Every 2 years or as recommended by Primary Care Provider</td>
</tr>
<tr>
<td></td>
<td>Mammogram (Female) Every 2 years or as recommended by Primary Care Provider</td>
</tr>
<tr>
<td></td>
<td>Prostate Specific Antigen (PSA) and rectal exam As recommended by Primary Care Provider</td>
</tr>
<tr>
<td></td>
<td>Colorectal Cancer Screening Every 2-10 years depending on your results and risk factors</td>
</tr>
<tr>
<td></td>
<td>Tetanus and Diphtheria shot Every 10 years</td>
</tr>
<tr>
<td></td>
<td>Flu shot Every Year even if healthy</td>
</tr>
<tr>
<td></td>
<td>Hepatitis B (Hep B) If not previously given or are at risk</td>
</tr>
<tr>
<td>65 and Older</td>
<td>Haemophilus influenza Type B (Hib) shot</td>
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<tr>
<td></td>
<td>Pneumonia shot (PPSV)</td>
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<tr>
<td></td>
<td>Varicella (chickenpox VZV) shot</td>
</tr>
<tr>
<td></td>
<td>Zoster (shingles) shot</td>
</tr>
<tr>
<td></td>
<td>Vision screening to check for eye diseases like glaucoma and diabetic retinopathy with risk factors like high blood pressure or diabetes</td>
</tr>
<tr>
<td></td>
<td>Hearing screening</td>
</tr>
</tbody>
</table>

At each checkup*, your Primary Care Provider may perform the following:

- Physical exam: Unclothed and covered
- Vital signs: Temperature, pulse, blood pressure, height, weight, body mass index (BMI)
- Health history, developmental and behavioral health assessment
- Sexually transmitted infection (STI) testing and protection
- Screenings: Vision, hearing
- Health Education and counseling: Injury/violence prevention, alcohol, tobacco, substance abuse, nutritional counseling, and physical activity
- Blood work: Hemoglobin or hematocrit
- Heart disease assessment or cholesterol screening
- Medication review with your Primary Care Provider. Also bring vitamins and supplements to your appointment.
- Catch-up on any shots that were previously missed
- Talk to your doctor about advance directives
- Referrals to specialists
- Bring list of questions or concerns to talk to your Primary Care Provider about
For people with asthma:
If you have not seen your Primary Care Provider in the last 3 months, call and make an appointment. Your Primary Care Provider can work with you to help keep your asthma under control and on track with your asthma action plan.

For people with diabetes:
If you have diabetes and have not seen your Primary Care Provider in the last 3 months, call and make an appointment. This is very important.

National guidelines say that people with diabetes should have the following:
• Blood Sugar Average, called a hemoglobin A1c (HbA1c). Should be checked at least twice a year (it should be less than 7%)
• LDL-cholesterol: Checked at least once a year (it should be less than 100mg/dL)
• A urine test for protein and microalbumin once a year
• Eye exam (dilated) by an eye doctor every year
• Routine foot exams

For people with high blood pressure:
If you have high blood pressure and have not seen your Primary Care Provider in the last 3 months, please call and make an appointment.

For women who need a mammogram:
Our records show that you may not have had a screening mammogram in the last year. Please call your Primary Care Provider and make an appointment.

For females who need a Pap smear:
Our records show that you may not have had a Pap smear in the last year. Please call your PCP and make an appointment.
ADVANCE DIRECTIVES

YOUR CARE IS YOUR DECISION
The law says you have a right to refuse medical treatment. This includes life-prolonging care. As your health plan, we have the responsibility of telling you about “advance directives.”

ADVANCE DIRECTIVES HELP YOU MAKE YOUR WISHES KNOWN
An advance directive is a legal document. It tells providers what type of care you want to get (or not get) if you are not able to tell them yourself. There are two types. One is a Living Will. The other is a Durable Power of Attorney for health care decisions.

A Living Will tells what type of care you want if you cannot make decisions yourself. It is used when you cannot make your wishes known to your doctor.

A Durable Power of Attorney for health care decisions names the person you want to make choices for you. It will be used if you are not able to make choices for yourself. It will also be used if you cannot tell your provider about the care you want.

You can change or stop your advance directives at any time. If you make changes, you should tell your provider and family.

Where can I get an advance directives form?
You can call a lawyer or your local legal aid office. You can also ask your provider or call Customer Service. Call 1-877-389-9457 (TTY 1-877-247-6272).

Whether or not you have an advance directive will not affect the type of care you receive.
MEMBER GRIEVANCE AND APPEAL PROCEDURES

We want you to let us know right away if you have any questions, concerns or problems with your covered services or the care you receive.

This section will explain how you can express your concerns or complaints.

There are two types of complaints you can make. They are called “grievances” and “appeals.” State law allows you to make a complaint if you have any problems with the plan. The state has also helped to set the rules for making a complaint and what we must do when we get a complaint. If you file a grievance or an appeal, we must be fair. We cannot disenroll you or treat you differently because you made a complaint.

What is a grievance?
A grievance is when you call or write to complain about a provider, the plan and/or service. Complaints may include:

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

A grievance does not include being unhappy with an action the plan made.

How do I file a grievance?
You or another person can file a grievance by calling or writing to us. Your doctor or another provider can also file a grievance with your written permission.

You must tell us that you agree to have someone else talk for you about your grievance. Call Customer Service at 1-877-389-9457 (TTY 1-877-247-6272). You may also write to:

WellCare of Kentucky
Attn: Grievance Department
P.O. Box 436000
Louisville, KY 40253
We can help you if you speak another language. You can also call Customer Service if you need help filing your grievance.

Within five business days of getting your grievance, we will mail you a letter telling you we received it. We will make a decision and mail you a letter within 30 days.

**What is an appeal?**

An appeal is a complaint you make when you want us to change a decision we made about your care. You can file one when we:

- Deny or limit a service request
- Reduce or stop services you have been getting
- Refuse to pay for services that you think should be covered
- Fail to give services in the required timeframe
- Fail to decide an appeal in the required timeframe

You will get a letter from us when any of these actions occur. This is called a “Notice of Action.” You can file an appeal if you think that the action was made in error.

**How do I file an appeal?**

You must file your appeal within 30 days from the date you receive your Notice of Action. You can file by calling or writing to us. If you file by calling, you must follow up with a written, signed appeal. If needed, we can help you file your appeal. You can also get help from others. Your provider or someone else you choose to act for you can help. They can file for you if you give them your written permission.

Types of representatives include:

- The legal guardian of a member who is a minor or an incapacitated adult
- Someone acting on behalf of the member with the member’s written permission
- The representative of a deceased member’s estate

You can file an appeal by calling Customer Service at **1-877-389-9457** (TTY **1-877-247-6272**). Or write to us at:

WellCare of Kentucky  
Attn: Appeals Department  
P.O. Box 436000  
Louisville, KY 40253

kentucky.wellcare.com    |    61
We can help you if you speak another language. You can also call Customer Service if you need help filing your grievance.

We will send you a letter within five business days from the receipt of your appeal. This letter will let you know we received it. We will then review it and send you a letter within 30 days telling you of our decision. You or someone you choose to act for you can review all of the information we used to make the decision.

**What if I need a fast (expedited) appeal?**

You or your doctor can ask for a fast appeal. We will give you a fast appeal if your doctor says waiting could seriously harm your health. You may also ask for a fast appeal without a doctor’s help. We will decide if you need a fast decision. You or your provider must call or fax us to ask for a fast appeal. Call 1-877-389-9457 (TTY 1-877-247-6272). Fax to 1-866-201-0657 or 813-262-2907. If your request was filed verbally, written notice is not needed. For fast appeals, we will call you. We will send a letter with the appeal decision within three days.

If you ask for a fast appeal and we decide that one is not needed, we will:

- Transfer the appeal to the timeframe for standard resolution
- Make reasonable efforts to try to call you
- Follow up within two days of written notice
- Inform you verbally and in writing that you may file a grievance about the denial of the expedited process

Punitive or retaliatory actions will not be taken against a member or service provider who files a grievance or appeal or a provider who supports a member’s grievance or appeal.

**What if I would like to submit additional information?**

You or someone appealing for you may give us more information. You may do this throughout the appeal review process.

The member or the representative has the opportunity before and during the appeals process to examine the member’s case file. This includes medical or clinical records (subject to HIPAA requirements) and any other documents and records considered during the appeals process.

You can also ask us for up to 14 more days for you to provide more information. We may also ask for 14 more days if we feel more information is needed and it is in your best interest.
What if I do not like the appeal decision?
You may not like the decision. You have the right to ask for a State Fair Hearing. Please see the State Fair Hearing section for details on this process.

MEDICATION APPEALS

What if I want to appeal a decision made about a medication? Do I do anything different?
You can still call Customer Service. (You must follow verbal requests with a signed written request within 10 days, but written medication appeals go to a different address.)

Send your appeal to:
WellCare Health Plans, Inc.
Attn: Pharmacy Medication Appeals Department
P.O. Box 436000
Louisville, KY 40253

Or you can fax it to 1-888-865-6531. We will send you a letter within 5 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.

How soon must I file my medication appeal?
Appeal within 30 calendar days of the date of our notice to you.

What if I want a fast or expedited medication appeal review?
Send an appeal for a decision we made on a prescription to:
WellCare Health Plans, Inc.
Attn: Pharmacy Medication Appeals Department.
P.O. Box 436000
Louisville, KY 40253

You can fax it too. Fax an appeal for a prescription to 1-888-865-6531. 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.
How soon must we decide on your appeal?

- 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. We will make it 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.

How will I be notified?

- 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 to verbally contact you, followed by a written notice

What if I do not like the medication appeal decision?

You may not like the decision. You have the right to ask for a State Fair Hearing. Please see the next section for details on this process.

CONTINUATION OF BENEFITS FOR MEDICAL AND MEDICATION APPEAL

a. The Plan will continue the member’s benefits if all of the following are met:

   1. The member or the service provider files a timely appeal of the Plan action or the member ask for a state fair hearing within 30 days from the date on the Plans notice of action;

   2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

   3. The services were ordered by an authorized service provider;
4. The time period covered by the original authorization has not expired; and
5. The member requests an extension of the benefits.

b. The Plan shall provide benefits until one of the following occurs:
   1. The member withdraws the appeal;
   2. 14 days have passed since the date of the resolution letter, provided the resolution of the appeal was against the member and the member has not requested a state fair hearing or taken any further action;
   3. The Cabinet issues a state fair hearing decision adverse to the member;
   4. The time period or service limits of a previously authorized service has expired.

c. If the final resolution of the appeal is adverse to the member, that is the Plan’s action is upheld, the Plan may recover the cost of the services furnished to the member while the appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(b).

STATE FAIR HEARINGS FOR MEDICAL AND MEDICATION APPEAL

What if I’m not satisfied with the results of my Appeal?
If you do not agree with a decision made by the Plan, you can ask for a State Fair Hearing at any time during the appeal process or you have up to 30 days of getting your appeal denial letter to mail in a written request for a hearing. Kentucky Medicaid will only take written requests. If you ask for a hearing on time, you will keep your benefits (except for EPSDT Special Services) through the hearing process.

If you are being denied a new service, you will not be able to get the service until the hearing is completed.

You will get a written notice of the hearing date. The notice will tell you what time the hearing is and where to go. The hearing will be close to your house. If you want to have the hearing on the phone, you can ask for that. The hearing date should be no more than 30 days from the date of your letter asking for a hearing. Before the hearing, you have the right to examine your case file and any documents or records that will be used at the hearing by Kentucky Medicaid.

Go to the hearing. If you don’t go, your case will be dismissed. At the hearing you will
explain your problem to the hearing officer and you can say why you should get that
service. You can bring a friend or a lawyer with you and any witnesses you believe may
be helpful. Medicaid may have a lawyer at the hearing also.

The hearing officer will mail you his recommended decision within 90 days of the
date of your signature on the letter asking for a hearing. You can file written notice to
Medicaid within 15 days of the decision. Medicaid will make a final decision within 90
days of the hearing officer’s recommended decision. If you still feel that the decision
is wrong, you can appeal to the Circuit Court. You have 30 days from the date of the
final order to make that appeal.

WEBSITE

Manage your health care by using the Web. Log on to kentucky.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
kentucky.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
• 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 1-877-389-9457 Monday through Friday, from 7 a.m. to 7 p.m. Eastern. TTY users may call 1-877-247-6272.

ENROLLMENT INFORMATION

ENROLLMENT
People covered under Kentucky Medicaid may join WellCare. There are certain requirements that you have to meet to be covered under Kentucky Medicaid. The Department of Community Based Services decides who is eligible.

90-DAY GRACE PERIOD
You have 90 days to try the plan after enrolling. If you want to, you can change plans during this time. This is called your Open Enrollment period. At the end of 90 days, you must stay in the plan until the next Annual Change period.

You may also change plans at any time if you have a “good cause” to do so. A good cause to change plans could involve the following:

• An administrative appeal decision
• Provisions in administrative rules or statutes
• A legal decision
• Relocation to a service area where the health plan does not provide service
• The plan’s refusal, because of moral or religious objections, to cover the service you may want
Other reasons include:

- Poor quality care
- Lack of access to services covered under the contract
- Lack of access to providers experienced in dealing with your health care needs
- Lack of direct access to certified nurse midwives, pediatric nurse practitioners, family nurse practitioners, if available in the geographic area in which the member resides
- Lack of direct access to women’s health care specialists for breast cancer screenings, Pap smears and pelvic exams

ANNUAL CHANGE

Every year, the state will have a period when you can change plans without cause. You will be notified 60 days prior to the time when you can make a change. If you meet with your DCBS worker early, he or she can accept your new selection during that meeting. If you receive SSI, or do not have to go into the DCBS office to renew your eligibility, you will receive information in the mail. If you do not choose a health plan, the State will choose a plan for you. For more information, call Customer Service at 1-877-389-9457 (TTY 1-877-247-6272).

REINSTATEMENT

If you lose your Medicaid eligibility but get it back within 60 days, the state will reinstate you as a member of WellCare.

IN VOLUNTARY DISENROLLMENT

You may lose your WellCare membership if you:

- No longer qualify based on the medical assistance eligibility criteria
- Voluntarily leave the program
- Die
- Are incarcerated
- Become a Medicare Special Savings Program recipient beneficiary
- Provide false information with the intent of enrolling in the program under false pretenses
- Choose another health plan during the annual plan change period and that health plan is not capped
• Enter a Waiver Program
• 30 days after entering a Nursing Facility for Long Term Care

You cannot be disenrolled from the plan for these reasons:
• Pre-existing medical conditions
• Missed appointments
• Changes in health status
• Utilization of medical services
• Diminished mental capacity
• Uncooperative or disruptive behavior resulting from the member’s special needs (except where the member’s continued enrollment in the health plan seriously impairs the health plan’s ability to furnish services to either the member or other members)

IMPORTANT INFORMATION ABOUT WELLCARE

PLAN STRUCTURE AND OPERATIONS
To learn more about the structure and operations of the plan, call Customer Service. Call 1-877-389-9457 (TTY 1-877-247-6272).

HOW OUR PROVIDERS ARE PAID
We work hard to give you the care you need. We work with many providers. You may ask how they are paid. And if how they are paid will affect how they use referrals. You may also ask if it will affect other services you may need. Call Customer Service for more information.

QUALITY AND MEMBER SATISFACTION INFORMATION
You can ask about how the plan has performed. You can also ask if our members are satisfied and/or provide ideas for how we can improve.

To do this, call Customer Service.
FRAUD AND ABUSE
Billions of dollars are lost to health care fraud every year. What is health care fraud and abuse? It’s when false information is given on purpose. This can be done by a member or provider. This false information can lead to someone getting a service or benefit that is not allowed. It can also lead to a provider receiving payment for services that were not performed.

Here are some other examples of fraud and abuse:
• Billing for a more expensive service than what was actually given
• Billing more than once for the same service
• Billing for services not actually performed
• Falsifying a patient’s diagnosis to justify tests, surgeries or other procedures that are not medically necessary
• Filing claims for services or medications not received
• Forging or altering bills or receipts
• Misrepresenting procedures performed to obtain payment for services that are not covered
• Over-billing the plan
• Using someone else’s WellCare ID card to get services
• Waiving patient co-pays or deductibles

If you know that fraud has occurred, tell us. Call our 24-hour fraud hotline. The toll-free number is 1-866-678-8355. It is private and you may leave a message without leaving your name. If you do leave your phone number, we will call you back. We’ll do this to be sure our information is complete and accurate. You can also report fraud on our website. Go to kentucky.wellcare.com. Submitting a report through the Web is private too.
MEMBER RIGHTS AND RESPONSIBILITIES

As a member of WellCare of Kentucky, 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, confidentiality and nondiscrimination.
- To have your privacy protected.
- To have a reasonable opportunity to choose a PCP and to change to another Provider in a reasonable manner.
- To agree to or refuse treatment and active participation in decision choices.
- 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 timely access to care that does not have any communication or physical access barriers.
- 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:
  - 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 used as a means of coercion, discipline, convenience, or retaliation.
• To ask for and get a copy of your medical records from your doctor in accordance with applicable federal and state law. 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 timely referral and access to medically indicated specialty care.

• To have your records kept private.

• To make your health care wishes known through advance directives.

• To prepare Advance Medical Directives pursuant to KRS311.621 to KRS311.643.

• To have a say in the plan’s member rights and responsibilities policy.

• To voice grievances and receive access to the grievance process, receive assistance in filing an appeal, and receive a hearing from the MCO and/or the Department for Medicaid Services.

• 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 under covered services co-payments.
  - The member’s rights to be responsible for cost sharing only as specified in the contract.

You have the responsibility:

• To become informed about member rights.

• To give information that the plan and its doctors and providers need to provide care.
• To abide by the MCO’s and Department’s policies and procedures
• To become informed about service and treatment options.
• To actively participate in personal health and care decisions, and practice healthy lifestyles.
• To report suspected fraud and abuse
• 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 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. (site address, or license number)
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
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;
• to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security and good order at the place where you are confined;
• in the unfortunate event of your death, to a coroner or medical examiner, for example, to determine the cause of death;
• to funeral directors as necessary to carry out their duties; and
• in the unfortunate event of your death, to organizations that procure or store organs, eyes or other tissues so that these organizations may investigate whether donation or transplantation is possible under law.

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