New Jersey
Member Handbook

WellCare®
Welcome to WellCare of New Jersey! We're glad you joined our family. As you work with everyone at WellCare, you'll see that we put you and your family first, so you get better care.

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

This member handbook will tell you more about your benefits and how your health plan works. Please read it and keep it in a safe place. We hope it will answer most of your questions. If it doesn’t, please call Customer Service at 1-888-453-2534 (TTY/TDD 1-877-247-6272). We have friendly staff trained to answer all of your questions. You can also visit us on the Web at newjersey.wellcare.com.

Be on the lookout for your WellCare identification (ID) card. You should receive it in the mail within a few days of this handbook. Keep reading for more information about your ID card and how to use it.

We wish you good health!

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Getting Started with Us
Getting Started with Us

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

**Check Your ID Card and Keep It in a Safe Place**

You’ll get your WellCare ID card in the mail. If you don’t receive it, call Customer Service toll free at 1-888-453-2534 (TTY/TDD 1-877-247-6272) within seven days after you’ve become our member. We’ll send you another one. You can also order a new one through our website at newjersey.wellcare.com. (Keep reading to learn more about it.)

When your ID card arrives, be sure to keep it with you at all times. You’ll need to show it every time you get care. Your ID card has important information on it about your plan. By showing your card, you can avoid getting a bill from the provider. (If you get a letter or voice message from a provider asking for your insurance/health plan information, call them right away. Give them your WellCare member information on your ID card. If you get a bill from a provider (who is either in or out of our network), call Customer Service at 1-888-453-2534 (TTY/TDD 1-877-247-6272). We’ll help to resolve the issue.)

You also need to look over the information on it. You’ll find your primary care provider’s (PCP) information, as well as your effective date (the date you became a WellCare member). If the PCP listed is not correct, call Customer Service and we’ll help you change to a new one. Call toll free 1-888-453-2534. Monday through Friday, 8 a.m. to 6 p.m. TTY/TDD users can call 1-877-247-6272. We’ll talk more about how to change your PCP on the next few pages.

If you ever lose your ID card, you can get a new one by calling Customer Service at 1-888-453-2534 (TTY/TDD 1-877-247-6272). Or log onto our website at newjersey.wellcare.com.
Get to Know Your PCP

Your PCP is your partner in health. He or she will help arrange all of your medical care. (He or she may hire someone, like a physician’s assistant, to help care for you.) This includes regular checkups, vaccinations and referrals to other providers, like specialists.

Our PCPs are trained in different specialties. They include:

- Family and internal medicine
- General practice
- Geriatrics
- Pediatrics
- Obstetrics/Gynecology (OB/GYN)

We encourage all of our new members (including those in NJ’s Division of Developmental Disabilities (DDD) program) to visit their PCPs within the first 90 days (3 months) of joining our plan. If you are pregnant, you should get prenatal care within 3 days to 3 weeks of joining our plan. (This depends on your risk factors and how long you’ve been pregnant.) (If you don’t, your PCP will reach out to you to schedule this.) This way your PCP will be able to get to know your health history and create a plan of care for you. Be sure to get your medical records from any doctors you’ve seen in the past. This will be very helpful to your PCP. (If you need help with this, call our Customer Service team at 1-888-453-2534 (TTY/TDD 1-877-247-6272).

If you didn't decide on a PCP before joining our plan, we chose one for you. We made this choice based on:

- 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)

If you have a special medical need, you can ask to have a specialist act as your PCP. Call Customer Service for more details.

Call 1-888-453-2534
(TTY/TDD 1-877-247-6272).

If you have a condition for which you need on-going care from one of our specialists, you can ask for a “standing referral.” This just means you can see the specialist without having to ask for a referral each time. Be sure to discuss this with your PCP.
If you are not happy with our PCP choice, you can change your PCP at any time. When choosing your new PCP, remember:

- Our providers are sensitive to the needs of many cultures
- We have providers who speak your language and understand your traditions and customs
- We can tell you about a provider’s schooling, residency and qualifications

Our provider directory is where you can find a list of the providers who give care to our members. (To request a provider directory, call Customer Service. Call 1-888-453-2534 (TTY/TDD 1-877-247-6272).) It lists:

- PCPs
- Hospitals
- Pharmacies
- Specialists
- Mental health providers
- Dentists

These providers make up our “provider network” or “network.”

We also have a tool on our website that helps you search for providers in your area. It’s called Find a Provider. Because we are always adding new providers to our network, the Find a Provider tool has the most current network information. Visit our website at newjersey.wellcare.com.

When you’re ready to make your PCP change, call Customer Service. Call 1-888-453-2534 (TTY/TDD 1-877-247-6272). You can request the change through our website too. If the change is made between the 1st and 10th of the month, it will go into effect right away. Changes made after the 10th of the month will become effective at the beginning of the next month. We’ll send you a new ID card with your new PCP listed on it.

There may be times when your PCP asks that we assign you to another PCP. We will look into the request if this should happen.

**Remember to Use the 24-Hour Nurse Advice Line**

This is our free 24-hour nurse advice line. And it’s available to you every day of the week. You can call it when you’re not sure what kind of care you need.

24-Hour Nurse Advice Line toll-free number: 1-888-453-2534 (TTY/TDD 1-877-247-6272)

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

• Need to go to the doctor or hospital
• Can care for yourself at home

You can get help with problems like:

• Back pain
• A cut or burn
• A cough or cold or the flu
• Dizziness or feeling sick

Remember, a nurse is always there to help. Consider calling the 24-Hour Nurse Advice Line before calling your doctor or going to the hospital. But if you think it is a real medical or dental emergency, call 9-1-1 first or go to the nearest emergency room.

In an Emergency...

Call 9-1-1 or go to the nearest emergency room.

We’ll talk more about emergencies later in this handbook.

Contact Us

Call us with any questions you have. We have a highly-trained Customer Service team ready to help. We can be reached Monday through Friday, 8 a.m. to 6 p.m.

Customer Service toll-free number:
1-888-453-2534
(TTY/TDD 1-877-247-6272)

You can call us any time you need help with:

• Getting a replacement ID card
• Changing your PCP
• Finding and choosing a provider
• Making an appointment with a provider
• Updating your contact information, like your mailing address and phone number
• Getting a schedule of orientation and educational event details

It’s also important for us to know if there’s a major change in your life. For example, if you:

• Get married or divorced
• Have a baby or adopt a child
• Experience the death of your spouse or child
• Start a new job
• Get health insurance from another company
We also want you to be comfortable when working with us and your providers. If you speak a different language or need something in Braille, large print or audio, don’t worry. We have translation and alternative format services available at no cost to you. Just give us a call.

If you call us after business hours with a non-urgent request, leave a message. We’ll call you back within 1 business day. (Don’t forget – our Nurse Advice Line is available 24 hours a day, seven days a week.) You can also write to our Customer Service team:

**WellCare**
Attn: Customer Service
P.O. Box 31370
Tampa, FL 33631-3370

**Our Website**
You may be able to find answers to your questions on our website. Visit [newjersey.wellcare.com](http://newjersey.wellcare.com) and click on “Medicaid” for information about the following:

- Our member handbook
- Provider directory and Find a Provider search tool
- Member newsletters
- Pediatric and adult preventive health
- Pregnancy care
- Childhood obesity, lead poisoning, asthma, diabetes and chronic kidney disease
- How we protect your privacy
- Your member rights and responsibilities

On our website, you can also:

- Change your primary care provider (PCP)
- Update your address and phone number
Know Your Rights and Responsibilities
As a member of our plan, you have rights and responsibilities. Don’t forget to read about these later in this handbook.

If You Have Other Health Insurance
If you or anyone in your family has health insurance with another company, we need to know. For example:

• If you work and have health insurance
• If your children have health insurance through their other parent
• If you’ve lost health insurance you had previously told us about

Not giving us this information can cause problems with you getting care and possible bills.

For more details, be sure to read the guide included with this handbook.

Hold onto This Handbook
You’ll find very valuable information in this handbook. Information about:

• Your covered benefits and services and how to get them
• Advance directives (learn more about these in the Advance Directives section later in this handbook)
• How to use our appeals and grievances process for when you’re not happy with a decision we made
• How we protect your privacy

If you lose your handbook, call Customer Service. Call 1-888-453-2534 (TTY/TDD 1-877-247-6272). We’ll send you a new one. You can also find it on our website at newjersey.wellcare.com.
Care Basics

You’ll get your care from doctors, hospitals and others who are in our provider network. We or a network doctor must approve your care.

We will pay for approved care. If you get a service that we do not approve, you may have to pay for it yourself.

Medically Necessary

We approve care that is “medically needed” or “necessary.” This simply means the care:

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

Making and Getting to Your Medical Appointments

We have guidelines to make sure you get to your medical appointments in a timely manner.\(^1\)\(^2\) (This is also called “access to care.”)

This table will give you an idea of how long it should take to get to a medical appointment.

<table>
<thead>
<tr>
<th>Type of Provider</th>
<th>Drive Time/Distance if You Live in an Urban Area</th>
<th>Distance if You Live in a Rural Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCPs and specialists</td>
<td>30 minutes to get to your appointment</td>
<td>20 miles</td>
</tr>
<tr>
<td>Hospitals</td>
<td>15 miles</td>
<td>15 miles</td>
</tr>
</tbody>
</table>

How long you should wait for an appointment depends on the kind of care you need. Keep these times in mind as you are setting your appointments.
<table>
<thead>
<tr>
<th>Type of Appointment</th>
<th>Type of Care</th>
<th>Appointment Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Emergency</td>
<td>Right away (both in and out of our service area), 24 hours a day, 7 days a week (prior authorization is not required for emergency services)</td>
</tr>
<tr>
<td></td>
<td>Urgent</td>
<td>Within 24 hours (1 day) of your request</td>
</tr>
<tr>
<td></td>
<td>PCP pediatric sickness</td>
<td>Within 24 hours (1 day) of your request</td>
</tr>
<tr>
<td></td>
<td>PCP adult sickness</td>
<td>Within 72 hours (3 days) of your request</td>
</tr>
<tr>
<td></td>
<td>Routine/wellness PCP visits</td>
<td>4 weeks (1 month) of your request</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>4 weeks (1 month) of your request</td>
</tr>
<tr>
<td></td>
<td>Non-emergency hospital visits</td>
<td>4 weeks (1 month) of your request</td>
</tr>
<tr>
<td></td>
<td>Follow-up care after a hospital stay</td>
<td>As needed</td>
</tr>
<tr>
<td>Dental</td>
<td>Emergency</td>
<td>Within 48 hours (two days) or sooner if needed</td>
</tr>
<tr>
<td></td>
<td>Urgent</td>
<td>Within 72 hours (3 days) of a referral</td>
</tr>
<tr>
<td></td>
<td>Routine visits</td>
<td>Within 30 days of a referral</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse</td>
<td>Emergency</td>
<td>Right away (both in and out of our service area), 24 hours a day, 7 days a week (prior authorization is not required for emergency services)</td>
</tr>
<tr>
<td></td>
<td>Urgent</td>
<td>Within 24 hours (1 day) of your request</td>
</tr>
<tr>
<td></td>
<td>Routine visit</td>
<td>Within 10 days of your request</td>
</tr>
</tbody>
</table>

1Our doctors must give you the same office hours as patients with other insurance.

2Members who are in NJ’s Division of Developmental Disabilities (DDD) program may choose network providers outside of the county in which they live.
Cost Sharing
As a part of the NJ FamilyCare Program, you may be required by the State of New Jersey to pay a premium or co-pay for care.

A premium is an amount you pay to the State each month for your health care coverage. It’s based on your income. A co-pay is what you must pay to a provider for care at the time it’s given.

Here are some important facts about premiums and co-pays:

• If you don’t pay your monthly premium on time, you could be disenrolled from the NJ FamilyCare Program
• You need to pay your premium to NJ FamilyCare, not WellCare
• You can find your co-pay amounts on your WellCare member ID card (we also list them in the Services Covered by WellCare section of this handbook)
• Your monthly premiums and co-pays cannot be more than 5 percent of your annual income; keep an eye on this and let the State know if you do go over the 5 percent mark in a calendar year
• If you are over 55 years old, benefits received are reimbursable to the State of New Jersey from your estate (this includes premiums)
Here’s a list of covered services. If you have any questions, call Customer Service at 1-888-453-2534 (TTY/TDD 1-877-247-6272).

Some services may be covered by the Division of Medical Assistance and Health Services (DMAHS) under fee-for-service Medicaid. They are listed here as “covered by Medicaid.” To get these services, you can talk with:

- Your PCP
- Your Medicaid caseworker
- Your local Medical Assistance Customer Center (MACC)
- Our Customer Service team

Help will be given to you about how to see a provider you choose.
<table>
<thead>
<tr>
<th>Service</th>
<th>Medicaid and NJ FamilyCare A</th>
<th>NJ Division of Developmental Disabilities (DDD)</th>
<th>NJ FamilyCare B</th>
<th>NJ FamilyCare C</th>
<th>NJ FamilyCare D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion and related services</td>
<td>(covered by Medicaid)</td>
<td>(covered by Medicaid)</td>
<td>(covered by Medicaid)</td>
<td>(covered by Medicaid)</td>
<td>(covered by Medicaid)</td>
</tr>
<tr>
<td>Acupuncture:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• When performed as a form of</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>anesthesia and part of a</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>covered surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audiology</td>
<td>(members under 16 years old)</td>
<td>(limited to administration of blood, processing of blood, processing fees and fees related to autologous blood donations)</td>
<td>(members under 16 years old)</td>
<td>(members under 16 years old)</td>
<td>(members under 16 years old)</td>
</tr>
<tr>
<td>Blood and blood plasma</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Service</td>
<td>Medicaid and NJ FamilyCare A</td>
<td>NJ Division of Developmental Disabilities (DDD)</td>
<td>NJ FamilyCare B</td>
<td>NJ FamilyCare C</td>
<td>NJ FamilyCare D</td>
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<td>-----------------</td>
<td>-----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Chiropractic services</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>(limited to spinal manipulation)</td>
<td>(limited to spinal manipulation)</td>
<td>(limited to spinal manipulation)</td>
<td>(limited to spinal manipulation with $5 co-pay)</td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>($5 co-pay except for preventive dental visits)</td>
<td>($5 co-pay except for preventive dental visits)</td>
<td></td>
</tr>
<tr>
<td>Diabetic supplies and equipment</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Durable medical equipment (DME) and assistive technology devices</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Limited benefit</td>
</tr>
<tr>
<td>Service</td>
<td>Medicaid and NJ FamilyCare A</td>
<td>NJ Division of Developmental Disabilities (DDD)</td>
<td>NJ FamilyCare B</td>
<td>NJ FamilyCare C</td>
<td>NJ FamilyCare D</td>
</tr>
<tr>
<td>---------------------------------------------</td>
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<td>-----------------------------------------------</td>
<td>-----------------</td>
<td>----------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Emergency services</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓ (with $10 co-pay for ER services)</td>
<td>✓ (with $35 co-pay for ER services, except when referred by PCP for services that should have been provided in PCP’s office or when admitted to the hospital)</td>
</tr>
<tr>
<td>EPSDT (Early and Periodic Screening, Diagnostic and Treatment) services</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(limited to well-child care, newborn hearing screenings, immunizations, lead screenings and treatment)</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Medicaid and NJ FamilyCare A</td>
<td>NJ Division of Developmental Disabilities (DDD)</td>
<td>NJ FamilyCare B</td>
<td>NJ FamilyCare C</td>
<td>NJ FamilyCare D</td>
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<td>-----------------------------------------------</td>
<td>-----------------</td>
<td>-----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Family planning</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

(includes medical history and physical exams, diagnostic and lab tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling; must use network providers) (certain NJ FamilyCare D members may use out-of-network providers; for more information, call us at 1-888-453-2534 (TTY/TDD 1-877-247-6272))
<table>
<thead>
<tr>
<th>Service</th>
<th>Medicaid and NJ FamilyCare A</th>
<th>NJ FamilyCare B</th>
<th>NJ FamilyCare C</th>
<th>NJ FamilyCare D</th>
<th>NJ Division of Developmental Disabilities (DDD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group homes and DYFS residential facilities</td>
<td>✓ (covered by Medicaid)</td>
<td>✓ (covered by Medicaid)</td>
<td>✓ (covered by Medicaid)</td>
<td>✓ (covered by Medicaid)</td>
<td>✓ (covered by Medicaid)</td>
</tr>
<tr>
<td>Hearing aids</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health</td>
<td></td>
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</tr>
<tr>
<td>Service</td>
<td>Medicaid and NJ FamilyCare A</td>
<td>NJ Division of Developmental Disabilities (DDD)</td>
<td>NJ FamilyCare B</td>
<td>NJ FamilyCare C</td>
<td>NJ FamilyCare D</td>
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<td>-----------------------------------------------</td>
<td>-----------------</td>
<td>-----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Hospice services:</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>• Includes room and board in a non-private institutional residence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital services (inpatient)</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Hospital services (outpatient)</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Intermediate care facilities/intellectual disability</td>
<td>☑ (covered by Medicaid)</td>
<td>☑ (covered by Medicaid)</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Service</td>
<td>Medicaid and NJ FamilyCare A</td>
<td>NJ FamilyCare B</td>
<td>NJ FamilyCare C</td>
<td>NJ FamilyCare D</td>
<td>NJ Division of Developmental Disabilities (DDD)</td>
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</tr>
<tr>
<td>Lab services:</td>
<td>• You should receive your results within 24 hours in emergency and urgent care cases</td>
<td>• You should receive your results within 24 hours in emergency and urgent care cases</td>
<td>• You should receive your results within 24 hours in emergency and urgent care cases</td>
<td>• You should receive your results within 24 hours in emergency and urgent care cases</td>
<td>• You should receive your results within 24 hours in emergency and urgent care cases</td>
</tr>
<tr>
<td>Maternity services:</td>
<td>• Includes related newborn care</td>
<td></td>
<td></td>
<td></td>
<td>(covered by Medicaid)</td>
</tr>
<tr>
<td>Medical day care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(covered by Medicaid)</td>
</tr>
</tbody>
</table>

- Lab services with $5 co-pay when not part of an office visit.
<table>
<thead>
<tr>
<th>Service</th>
<th>Medicaid and NJ FamilyCare A</th>
<th>NJ Division of Developmental Disabilities (DDD)</th>
<th>NJ FamilyCare B</th>
<th>NJ FamilyCare C</th>
<th>NJ FamilyCare D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical supplies</td>
<td>(covered by Medicaid)</td>
<td>(covered by Medicaid)</td>
<td>(covered by Medicaid)</td>
<td>(covered by Medicaid)</td>
<td>(covered by Medicaid)</td>
</tr>
<tr>
<td></td>
<td>(limited to diabetic and family planning supplies)</td>
<td>(limited to 35 days per year; no limit of days for members under 19 years old)</td>
<td>(covered by WellCare)</td>
<td>(covered by Medicaid)</td>
<td>(covered by Medicaid)</td>
</tr>
<tr>
<td>Service</td>
<td>Medicaid and NJ FamilyCare A</td>
<td>NJ Division of Developmental Disabilities (DDD)</td>
<td>NJ FamilyCare B</td>
<td>NJ FamilyCare C</td>
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<td>----------------</td>
</tr>
<tr>
<td>Mental health (outpatient services)</td>
<td>(covered by Medicaid)</td>
<td>(covered by Medicaid)</td>
<td>(covered by Medicaid)</td>
<td>(covered by Medicaid)</td>
<td>(covered by Medicaid)</td>
</tr>
<tr>
<td>Mental health (home health)</td>
<td>(covered by Medicaid)</td>
<td>(covered by WellCare)</td>
<td>(covered by WellCare)</td>
<td>(covered by Medicaid)</td>
<td>(covered by Medicaid)</td>
</tr>
</tbody>
</table>

- Mental health services covered by Medicaid, except for mental health screenings, referrals, prescription drugs, and for treatment or diagnosis of altered mental status.
- Mental health services covered by WellCare, limited to 20 visits per year (no limit for CHIP members under 19 years old).
<table>
<thead>
<tr>
<th>Service</th>
<th>Medicaid and NJ FamilyCare A</th>
<th>NJ Division of Developmental Disabilities (DDD)</th>
<th>NJ FamilyCare B</th>
<th>NJ FamilyCare C</th>
<th>NJ FamilyCare D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse midwife services (prenatal)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(with $5 co-pay for 1st prenatal visit only)</td>
</tr>
<tr>
<td>Nurse midwife services (postpartum)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(with $5 co-pay per visit)</td>
</tr>
<tr>
<td>Nurse practitioner services</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(with $5 co-pay per visit, except for preventive care services)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(with $5 co-pay per visit during normal office hours, except for preventive care services; $10 co-pay for non-office hours and home visits)</td>
</tr>
<tr>
<td>Service</td>
<td>Medicaid and NJ FamilyCare A</td>
<td>NJ Division of Developmental Disabilities (DDD)</td>
<td>NJ FamilyCare B</td>
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<td>-----------------</td>
</tr>
<tr>
<td>Nursing facility care:</td>
<td>✓ (inpatient rehabilitation services may be provided in this setting when appropriate)</td>
<td>✓ (inpatient rehabilitation services may be provided in this setting when appropriate)</td>
<td>Not covered (inpatient rehabilitation services may be provided in this setting when appropriate)</td>
<td>Not covered (inpatient rehabilitation services may be provided in this setting when appropriate)</td>
<td>Not covered</td>
</tr>
<tr>
<td>Service</td>
<td>Medicaid and NJ FamilyCare A</td>
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<td>-----------------</td>
</tr>
<tr>
<td>Optical appliances:</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• You can choose eyeglasses or contact lenses from select frames or contact lenses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Eyeglasses and contact lenses are covered as follows:</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Ages 0–20 or 60 and older are eligible for eyeglasses or contact lenses every year if the prescription changes, or more frequently if medically necessary</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Service</td>
<td>Medicaid and NJ FamilyCare A</td>
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</tr>
<tr>
<td>- Ages 21–59 are eligible for eyeglasses or contact lenses every 2 years if the prescription changes, or more frequently if medically necessary</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Contact lenses are covered for the initial contact lens supply and related fees in full when covered brands are prescribed;</td>
<td></td>
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<tr>
<td>Service</td>
<td>Medicaid and NJ FamilyCare A</td>
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</tr>
<tr>
<td>anything above the $100 contact lens limit will be out of pocket if not medically necessary; if contact lenses are medically necessary, anything above the $100 limit is covered and requires prior authorization</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- The benefit period starts the day the eyeglasses or contact lenses are dispensed</td>
<td></td>
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</tr>
<tr>
<td>Service</td>
<td>NJ FamilyCare D</td>
<td>NJ FamilyCare C</td>
<td>NJ FamilyCare B</td>
<td>NJ Division of Developmental Disabilities (DDD)</td>
<td>Medicaid and NJ FamilyCare A</td>
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<td>-------------------------------------------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Optometrist services:</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Includes one yearly eye exam for all ages. (additional exams require PCP referral, with $5 co-pay, except for newborns covered under Medicaid fee-for-service)</td>
<td>(with $5 co-pay)</td>
<td>(with $5 co-pay)</td>
<td>(with $5 co-pay)</td>
<td>(with $5 co-pay, except for newborns covered under Medicaid fee-for-service)</td>
</tr>
<tr>
<td>Organ transplants:</td>
<td>• If you're placed on a transplant list before joining WellCare, coverage is limited to transplant-related costs for the donor and recipient.</td>
<td>• If you're placed on a transplant list before joining WellCare, coverage is limited to transplant-related costs for the donor and recipient.</td>
<td>• If you're placed on a transplant list before joining WellCare, coverage is limited to transplant-related costs for the donor and recipient.</td>
<td>• If you're placed on a transplant list before joining WellCare, coverage is limited to transplant-related costs for the donor and recipient.</td>
<td>• If you're placed on a transplant list before joining WellCare, coverage is limited to transplant-related costs for the donor and recipient.</td>
</tr>
<tr>
<td>Service</td>
<td>Medicaid and NJ FamilyCare A</td>
<td>NJ Division of Developmental Disabilities (DDD)</td>
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<td>NJ FamilyCare C</td>
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</tr>
<tr>
<td>• If you’re placed on a transplant list while a member of WellCare,</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>coverage is provided by WellCare and includes all donor and recipient</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>transplant costs (covered even if you have the transplant performed</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>within 2 months after disenrolling from WellCare)</td>
<td></td>
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</tr>
<tr>
<td>Service</td>
<td>NJ FamilyCare A</td>
<td>NJ FamilyCare B</td>
<td>NJ FamilyCare C</td>
<td>NJ FamilyCare D</td>
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</tr>
<tr>
<td>Orthodontic treatment services:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Provided to children under 19 years old when medically necessary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthotics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient diagnostic testing</td>
<td></td>
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</tr>
<tr>
<td>If you’re placed on a transplant list while with another health plan and then transfer to WellCare, WellCare and the other health plan you were with will work out the costs</td>
<td>√</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Not covered</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Table Notes:**
- √ indicates coverage is included.
- Not covered indicates coverage is not included.
<table>
<thead>
<tr>
<th>Service</th>
<th>Medicaid and NJ FamilyCare A</th>
<th>NJ Division of Developmental Disabilities (DDD)</th>
<th>NJ FamilyCare B</th>
<th>NJ FamilyCare C</th>
<th>NJ FamilyCare D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial care services</td>
<td>✓ (covered by Medicaid)</td>
<td>✓ (covered by Medicaid)</td>
<td>✓ (covered by Medicaid)</td>
<td>✓ (covered by Medicaid)</td>
<td>✓ (covered by Medicaid)</td>
</tr>
<tr>
<td>Partial hospital program services</td>
<td>✓ (covered by Medicaid)</td>
<td>✓ (covered by Medicaid)</td>
<td>✓ (covered by Medicaid)</td>
<td>✓ (covered by Medicaid)</td>
<td>✓ (covered by Medicaid)</td>
</tr>
<tr>
<td>Personal care assistant services</td>
<td>✓ (covered by Medicaid)</td>
<td>✓ (covered by Medicaid)</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Podiatrist services:</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓ (with $5 co-pay)</td>
<td>✓ (with $5 co-pay)</td>
</tr>
<tr>
<td>• Excludes routine hygienic care of feet, including treatment of corns, calluses, trimming of nails and other hygienic care in the absence of a pathological condition</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Service</td>
<td>Medicaid and NJ FamilyCare A</td>
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<td>NJ FamilyCare C</td>
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<td>-----------------</td>
</tr>
<tr>
<td>Prescription drugs (retail pharmacy):</td>
<td><img src="https://via.placeholder.com/15" alt="✓" /></td>
<td><img src="https://via.placeholder.com/15" alt="✓" /></td>
<td><img src="https://via.placeholder.com/15" alt="✓" /></td>
<td><img src="https://via.placeholder.com/15" alt="✓" /></td>
<td><img src="https://via.placeholder.com/15" alt="✓" /></td>
</tr>
<tr>
<td>• ABD members with Medicare are covered under Medicare Part D</td>
<td><img src="https://via.placeholder.com/15" alt="✓" /></td>
<td><img src="https://via.placeholder.com/15" alt="✓" /></td>
<td><img src="https://via.placeholder.com/15" alt="✓" /></td>
<td><img src="https://via.placeholder.com/15" alt="✓" /></td>
<td><img src="https://via.placeholder.com/15" alt="✓" /></td>
</tr>
<tr>
<td>• Erectile dysfunction drugs, anti-obesity and cosmetic agents not covered</td>
<td><img src="https://via.placeholder.com/15" alt="✓" /></td>
<td><img src="https://via.placeholder.com/15" alt="✓" /></td>
<td><img src="https://via.placeholder.com/15" alt="✓" /></td>
<td><img src="https://via.placeholder.com/15" alt="✓" /></td>
<td><img src="https://via.placeholder.com/15" alt="✓" /></td>
</tr>
<tr>
<td>• Certain cough/cold and topical items not covered for certain ages</td>
<td><img src="https://via.placeholder.com/15" alt="✓" /></td>
<td><img src="https://via.placeholder.com/15" alt="✓" /></td>
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<td><img src="https://via.placeholder.com/15" alt="✓" /></td>
</tr>
</tbody>
</table>

- **$1 co-pay on generic drugs (covered by WellCare)**
- **$5 co-pay on brand-name drugs (covered by WellCare)**
- **$5 co-pay on drugs if supply is less than 34 days (covered by WellCare)**
- **$10 co-pay on drugs if supply is greater than 34 days (covered by WellCare)**
<table>
<thead>
<tr>
<th>Service</th>
<th>Medicaid and NJ FamilyCare A</th>
<th>NJ Division of Developmental Disabilities (DDD)</th>
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<th>NJ FamilyCare D</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Prescription drugs (given by doctor)</td>
<td>Covered by Medicare Part B</td>
<td>Co-Pays for Medicare Part B</td>
<td>Covered drugs considered DME and used in home covered by Medicaid (i.e., insulin given through an insulin pump)</td>
<td>Covered drugs considered DME and used in home covered by Medicaid (i.e., insulin given through an insulin pump)</td>
</tr>
<tr>
<td>Service</td>
<td>Medicaid and NJ FamilyCare A</td>
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</tr>
<tr>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Primary care, specialty care and women’s health services</td>
<td></td>
<td></td>
<td></td>
<td>(with $5 co-pay per visit; no co-pay for well-child visits, lead screenings or treatment, necessary immunizations, prenatal care, or PAP tests)</td>
<td>(when authorized by WellCare)</td>
</tr>
<tr>
<td>Private-duty nursing</td>
<td></td>
<td></td>
<td></td>
<td>(children under 21 years old)</td>
<td>(children under 21 years old)</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>(children under 21 years old)</td>
<td>(children under 21 years old)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(children under 21 years old)</td>
<td>(children under 21 years old)</td>
</tr>
</tbody>
</table>

- **Primary care, specialty care and women’s health services**:
  - Medicaid and NJ FamilyCare A
  - NJ Division of Developmental Disabilities (DDD)
  - NJ FamilyCare B
  - NJ FamilyCare C
  - NJ FamilyCare D

- **Private-duty nursing**:
  - Medicaid and NJ FamilyCare A
  - NJ Division of Developmental Disabilities (DDD)
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  - NJ FamilyCare C
  - NJ FamilyCare D
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<thead>
<tr>
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<th>NJ FamilyCare D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosthetics</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

Prosthetics (limited to the initial delivery of a prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired due to disease, injury or congenital defect; repair services and replacement are covered only when needed due to congenital growth).
<table>
<thead>
<tr>
<th>Service</th>
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<th>NJ FamilyCare C</th>
<th>NJ FamilyCare D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiology services (diagnostic and therapeutic):</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• You should receive your results within 24 hours in emergency and urgent care cases</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• You should receive your results within 10 business days in non-emergency and non-urgent care cases</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓ (with $5 co-pay when not part of an office visit)</td>
</tr>
<tr>
<td>Service</td>
<td>Medicaid and NJ FamilyCare A</td>
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<td>---------------</td>
</tr>
<tr>
<td>Rehabilitation services (cognitive, physical, occupational and speech therapies)</td>
<td>✔</td>
<td>✔</td>
<td>✔ (limited to 60 visits per therapy, per incident, per calendar year)</td>
<td>✔ (limited to 60 visits per therapy, per incident, per calendar year)</td>
<td>✔ (with a $5 co-pay; limited to 60 visits per therapy, per incident, per calendar year; speech therapy for developmental delay not covered unless resulting from disease, injury or congenital defects)</td>
</tr>
<tr>
<td>Sex abuse exams</td>
<td>✔ (covered by Medicaid)</td>
<td>✔ (covered by Medicaid)</td>
<td>✔ (covered by Medicaid)</td>
<td>✔ (covered by Medicaid)</td>
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</tr>
<tr>
<td>Social necessity days</td>
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<td>✔ (covered by Medicaid)</td>
<td>✔ (covered by Medicaid)</td>
<td>✔ (covered by Medicaid)</td>
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</tr>
<tr>
<td></td>
<td>(limited to up to 12 inpatient hospital days)</td>
<td>(limited to up to 12 inpatient hospital days)</td>
<td>(limited to up to 12 inpatient hospital days)</td>
<td>(limited to up to 12 inpatient hospital days)</td>
<td>(limited to up to 12 inpatient hospital days)</td>
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<td>Service</td>
<td>Medicaid and NJ FamilyCare A</td>
<td>NJ Division of Developmental Disabilities (DDD)</td>
<td>NJ FamilyCare B</td>
<td>NJ FamilyCare C</td>
<td>NJ FamilyCare D</td>
</tr>
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<tr>
<td>Substance abuse</td>
<td>✓ (covered by Medicaid)</td>
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<td>✓ (covered by Medicaid)</td>
<td>✓ (covered by Medicaid)</td>
<td>✓ (limited to detoxification services only)</td>
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<td>Transportation – ground emergency</td>
<td>✓</td>
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<td>✓</td>
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<td>Transportation – non-emergency (mobile assisted vehicles (MAVs) and non-emergency basic life support)</td>
<td>✓ (covered by Medicaid)</td>
<td>✓ (covered by Medicaid)</td>
<td>✓ (covered by Medicaid)</td>
<td>✓ (covered by Medicaid)</td>
<td>Not covered</td>
</tr>
<tr>
<td>Service</td>
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<td>NJ Division of Developmental Disabilities (DDD)</td>
<td>NJ FamilyCare C</td>
<td>NJ FamilyCare D</td>
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<tr>
<td></td>
<td>✓ (covered by Medicaid)</td>
<td>✓ (covered by Medicaid)</td>
<td>✓ (covered by Medicaid)</td>
<td>✓ (covered by Medicaid)</td>
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<tr>
<td></td>
<td>Transportation – livery (taxi, bus, car service) - includes reimbursement for mileage</td>
<td>Waiver and demonstration program services (except DDD-waiver)</td>
<td>Not covered</td>
<td>Not covered</td>
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</table>
# Services NOT Covered by WellCare or Medicaid

<table>
<thead>
<tr>
<th>Non-Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• All claims arising directly from services provided by or in institutions owned or operated by the federal government, such as Veterans Administration hospitals</td>
</tr>
<tr>
<td>• All services that are not medically necessary</td>
</tr>
<tr>
<td>• Any services or items furnished for which your provider does not normally charge</td>
</tr>
</tbody>
</table>
| • Cosmetic surgery  
  *Exception: when it’s medically necessary and approved* |
| • Experimental organ transplants |
| • Respite care |
| • Rest cures, personal comfort and convenience items, services and supplies not directly related to your care, including but not limited to:  
  - Guest meals and accommodations  
  - Telephone charges  
  - Travel expenses  
  - Take-home supplies and similar costs  
  *Exception: Costs incurred by an accompanying parent(s) for an out-of-state medical intervention are covered under EPSDT services* |
| • Services billed for which the corresponding health care records do not adequately and legibly reflect the requirements of the procedure described or procedure code used by the billing provider |
| • Services involving the use of equipment in facilities, the purchase, rental or construction of which has not been approved by applicable laws of the State of New Jersey |
## Non-Covered Services

- Services or items furnished for any condition or accidental injury arising out of and in the course of employment for which any benefits are available under the provisions of any workers' compensation law, temporary disability benefits law, occupational disease law, or similar legislation, whether or not you claim or receive benefits there under, and whether or not any recovery is obtained from a third-party for resulting damages.

- Services or items furnished for any sickness or injury occurring while you are on active duty in the military.

- Services or items reimbursed based upon submission of a cost study when there are no acceptable records or other evidence to substantiate either the costs allegedly incurred or beneficiary income available to offset those costs; in the absence of financial records, a provider may substantiate costs or available income by means of other evidence acceptable to the Division of Medical Assistance and Health Services.

- Services provided by an immediate relative or member of your household.

- Services provided in an inpatient psychiatric institution (that is not an acute care hospital) if you are under 65 years of age and over 21 years of age.

- Services provided outside of the United States and its territories.

- Services provided primarily for the diagnosis and treatment of infertility, including:
  - Sterilization reversals and related office visits (medical or clinic)
  - Drugs
  - Laboratory services
  - Radiological and diagnostic services and surgical procedures

- Services provided to all persons without charge; services and items provided without charge through programs of other public or voluntary agencies (for example, New Jersey State Department of Health and Senior Services, New Jersey Heart Association, First Aid Rescue Squads, etc.) shall be used as much as possible.

- That part of any benefit which is covered or payable under any health, accident or other insurance policy (including any benefits payable under the NJ no-fault automobile insurance laws), any other private or governmental health benefit system, or through any similar third-party liability, which also includes the provision of the Unsatisfied Claim and Judgment Fund.
How to Get Covered Services

Call your PCP when you need regular care. He or she will send you to see a specialist for tests, specialty care and other covered services that he or she doesn’t provide. Be sure your PCP approves you to see a specialist. We will cover this care.

If your PCP does not provide an approved service, ask him or her how you can get it.

Prior Authorization

Prior authorization means we must approve a service or prescription before you can get it. Your PCP or specialist will contact us to ask for this approval. If we do not approve the request, we will let you know. We will give you information about our appeals process and your right to a Medicaid Fair Hearing, if you are eligible, and do not agree with our decision.

The following services require prior authorization:

- DME rentals, DME purchases over $250, orthotics and prosthetics over $500
- Home health services
- Elective inpatient procedures
- Inpatient admissions
- Long-term acute care hospital admission
- Inpatient rehabilitation facility admissions
- Skilled nursing facility admissions
- Advanced radiology
- Genetic and reproductive lab testing
- Investigation and experimental procedures
- Outpatient therapy services
- Select outpatient procedures
  (please contact Customer Service for specific procedures)
We make a prior authorization decision for non-emergency services within 10 business days or sooner of the request.

You or your PCP/specialist can ask us to make a fast decision instead. (A fast decision is made within 24 hours.) You can ask for this if you or your PCP/specialist feel(s) that waiting for a decision could put your life or health in danger. To request this, call Customer Service at 1-888-453-2534 (TTY/TDD 1-877-247-6272). The request can also be faxed to us at 1-877-297-3112. When you make this request, be sure to ask us for a fast decision.

Sometimes we may need more time to make a fast decision. If so, we will then make a decision within 3 business days.

**Services Available Without Authorization**

You do not need approval from us or your PCP for the following services:

- DME purchases under $250, orthotics and prosthetics under $500
- Emergency or urgent care services
- Emergency transportation services
- Observation services
- Routine lab test
- Dialysis
- Hospice services
- Office visits with in-network specialists
- Routine radiology services
- Select outpatient procedures (please contact Customer Service for specific procedures)
Even though you don’t need approval for these services, you will need to pick a network provider. Refer to your provider directory to choose one. (Don’t forget about our online provider search tool – Find a Provider – on our website. Go to newjersey.wellcare.com.) When you make your choice, call to set up an appointment and remember to take your ID card with you.

**Services from Providers Not in Our Network**

There may be times when a service you need is not available using a network provider. If this happens, your PCP will work with us to arrange that service. We’ll cover it out-of-network. (Prior authorization may be needed.) We’ll also make sure that the cost to you (the co-pay – if you have one) is no more than it would be if the service was done by a network provider.

**Utilization Management**

Utilization management (UM) is a common process used by health plans. It’s how they make sure members get the right care at the right place. It also helps them control costs and deliver good care at the same time. Our UM program has four parts. They are:

- Prior authorization: getting our approval before getting a service
- Prospective reviews: before you get care, we make sure it is right for you
- Concurrent reviews: reviewing your care as you get it to see if something else might be better for you
- Retrospective reviews: finding out if the care you got was appropriate

At times, we must deny coverage for services or care. These denial decisions are made by our Medical Director. Here are some things you should know about that:

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

Call Customer Service if you have questions about our UM program. Call 1-888-453-2534 (TTY/TDD 1-877-247-6272).

**Second Medical Opinion**

Call your PCP when you want a second opinion about your care. He or she will ask you to pick another WellCare network doctor in your area. If you can’t find one, you’ll be able to choose a doctor who is not in our network. Don’t worry – you don’t pay for these services. But, you must go to a WellCare network provider for any tests the second-opinion doctor wants.
Your PCP will review the second opinion. He or she will then decide the best way to treat you. Remember, you may have to pay for services you get when you go to a doctor who’s not in our network without approval.

**After-Hours Care**

What if you get sick or hurt when your PCP’s office is closed? If it’s not an emergency, call your PCP anyway. The number is on your ID card.

Your PCP’s office will have a doctor “on call,” who is available 24 hours a day, 7 days a week. He or she will call you back and tell you what to do. You may go to an urgent care center if you can’t reach your PCP’s office. You don’t need prior approval to go to an urgent care center. If you do go to one, please call your PCP’s office the next day for follow-up care.

**Emergency Care**

A medical emergency means your health is in serious danger. An emergency is when the condition could cause:

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

For pregnant women, it may be an emergency if you think:

- That you are in labor
- There is no time to go to your doctor’s regular hospital
- That going to another hospital may cause harm to you and your baby

Here are some examples of emergencies:

- Broken bones or cuts requiring stitches
- Heart attack or severe chest pains
- Shortness of breath
- Poisoning
- Heavy blood loss
- Loss of consciousness
In case of an emergency, call 9-1-1. Or go to the nearest hospital emergency room (ER) right away. The choice is yours. Call our 24-Hour Nurse Advice Line or your doctor if you are not sure it is an emergency. You do not need pre-approval for emergency care that is provided at any urgent care center or ER.

We will cover this care when it’s reasonable to think your condition will get worse without care right away.

When you get to the ER, show your WellCare ID card. Ask the staff to call us. The ER doctor will decide if your visit is an emergency. If your condition is not an emergency and your health is not in danger, you can choose to stay. But, you may have to pay for the care.

Be sure to let your PCP know, as soon as you can, when you are in the hospital. Also let him or her know if you get care in an ER or urgent care center.

We will cover any follow-up care that your doctor says you need.

**Special Needs Care**

We offer care management services to children and adults with special health care needs. Our care management programs are offered to members who:

- Are home-bound
- Are identified as needing assistance in accessing or using services
- Have long-term or complex health conditions, like asthma, diabetes, HIV/AIDS and high-risk pregnancy

Our care managers are trained to help you, your family and your PCP arrange services (including referrals to special care facilities for highly-specialized care) you may need to manage your illness. Our goal is to help you understand how to take care of yourself and maintain good health.

**Out-of-Area Emergency Care**

It’s important to get care when you are sick or hurt — even when you travel. Call Customer Service if you get sick or injured while traveling. The toll-free number is 1-888-453-2534 (TTY/TDD 1-877-247-6272).

If you have an emergency while traveling, go to the nearest hospital. It doesn’t matter if you’re not in our service area. Show your ID card. Call your PCP as soon as you can. Also ask the hospital staff to call us for instructions on how to file your claim.

**Post-Stabilization Care**

It is important that you get care until your condition is stabilized. We will pay for the care you get after your ER visit. This is called “post-stabilization” care. You do not need pre-approval for post-stabilization services. But, this care must be needed to maintain, improve or resolve your medical condition.
Our care management programs offer you a care manager and other outreach workers. They’ll work one-on-one with you to help coordinate your health care needs. To do this, they:

- May ask you questions to get more information about your condition
- Will work with your PCP to arrange services you need and help you understand your illness
- Will provide information to help you understand how to care for yourself and how to access services, including local resources
- You may be contacted about care management if:
  - You ask for these services
  - Your PCP asks that you be placed into a care management program
  - We feel you meet the requirements for one of our care management programs

Talk with your PCP about these services. Or call Customer Service to learn more. Call 1-888-453-2534 (TTY/TDD 1-877-247-6272).

Treatment of Minors

WellCare will provide care for members younger than 18, following all applicable laws. Treatment will be at the request of the minor’s parent(s) or other person(s) who have legal responsibility for the minor’s medical care. However, New Jersey law allows minors to make health care decisions for themselves in some cases.

We will allow treatment in the following cases:

- When minors go to an emergency room for treatment, and that treatment is provided because of an emergency medical condition. The minor will be treated without parental consent.
- When minors want family planning services, maternity care or service related to sexually transmitted diseases (STDs). These services will be rendered as medically necessary without parental consent.
- When minors living on their own and have their own Medicaid ID number as head of their own household need treatment.
Pregnancy and Newborn Care

When you find out you’re pregnant, taking care of yourself can help you and your unborn baby stay healthy.

You should see your PCP within 3 days to 3 weeks of joining our plan. (This depends on your risk factors and how long you’ve been pregnant.) Be sure to go to all your prenatal and postpartum (after birth) visits. Customer Service can help set up these appointments. Just call us at 1-888-453-2534 (TTY/TDD 1-877-247-6272).

Be sure to let us know when you become pregnant. We can provide you with helpful information about having and caring for your baby. We can also enroll you in our free Prenatal Rewards Program.

Here are a couple of other important things to remember:

• If you have a baby while you’re a WellCare member, we will cover him or her from birth.
• You must call the County Welfare Agency in your county to get your baby’s Medicaid ID number. Don’t forget to call us to give us this number.
• You need to choose a PCP for your baby. That way your baby can get needed checkups and immunizations. You must do this by the time your baby is born. If you don’t, we’ll choose one for you.

Women, Infants and Children (WIC)

WIC is a special nutrition program. It’s for women (pregnant and those who have recently delivered), infants and children. The program provides:

• Nutrition education
• Nutritious food
• Referrals to other health, welfare and social services
• Support for breastfeeding mothers

If you are pregnant, ask your PCP about WIC. To see if you’re eligible and to apply for this program, call your local WIC agency. You will need to schedule an appointment to talk with them. You’ll need to provide proof of New Jersey residency and your income.
<table>
<thead>
<tr>
<th>Region</th>
<th>Agency Name</th>
<th>Service Area</th>
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</thead>
<tbody>
<tr>
<td>North</td>
<td>St. Joseph’s WIC Program</td>
<td>Bergen, Morris and Passaic counties (except the city of Passaic – see next)</td>
</tr>
<tr>
<td></td>
<td>185 6th Avenue, Paterson, NJ 07524</td>
<td>(973) 754-4575</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:wic@sjhmc.org">wic@sjhmc.org</a></td>
<td></td>
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<tr>
<td></td>
<td>Passaic WIC Program</td>
<td>City of Passaic</td>
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<tr>
<td></td>
<td>333 Passaic Street, Passaic, NJ 07055</td>
<td>(973) 365-5620</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:passaicwic@cityofpassaicnj.gov">passaicwic@cityofpassaicnj.gov</a></td>
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<tr>
<td>North</td>
<td>North Hudson WIC Program</td>
<td>Hudson County (except Bayonne and Jersey City – see next)</td>
</tr>
<tr>
<td></td>
<td>407 39th Street, Union City, NJ 07087</td>
<td>(201) 866-4700</td>
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<tr>
<td></td>
<td>Email: <a href="mailto:klazarowitz@nhcac.org">klazarowitz@nhcac.org</a></td>
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<td></td>
<td>Email: <a href="mailto:rlavagnino@nhcac.org">rlavagnino@nhcac.org</a></td>
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<td></td>
<td>Jersey City WIC Program</td>
<td>Bayonne and Jersey City</td>
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<tr>
<td></td>
<td>384 Martin Luther King Drive, The Hub, Jersey City, NJ 07304</td>
<td>(201) 547-5682</td>
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<tr>
<td></td>
<td>Email: <a href="mailto:help@JCWIC.org">help@JCWIC.org</a></td>
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<tr>
<td></td>
<td>East Orange WIC Program</td>
<td>Essex County: Belleville, Bloomfield, Caldwell, Cedar Grove, East Orange, Essex Falls, Fairfield, Glen Ridge, Livingston, Millburn, Montclair, North Caldwell, Nutley, Orange, Roseland, South Orange, Verona, West Caldwell and West Orange</td>
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<tr>
<td></td>
<td>185 Central Avenue Suites 505 &amp; 507, East Orange, NJ 07018</td>
<td>(973) 395-8960</td>
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<tr>
<td></td>
<td>Email: <a href="mailto:monica@ci.east-orange.nj.us">monica@ci.east-orange.nj.us</a></td>
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<tr>
<td></td>
<td>Newark WIC Program</td>
<td>Essex County: Belleville, Bloomfield, East Orange, Irvington, Maplewood, Newark, Orange and South Orange</td>
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<tr>
<td></td>
<td>110 Williams Street, Newark, NJ 07102</td>
<td>(973) 733-7628</td>
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<tr>
<td></td>
<td>Email: <a href="mailto:reynoldsc@ci.newark.nj.us">reynoldsc@ci.newark.nj.us</a></td>
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<tr>
<td></td>
<td>UMDNJ WIC Program</td>
<td>Essex County: Irvington and Newark (also open to NJ residents being treated at UMDNJ)</td>
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<tr>
<td></td>
<td>Stanley Bergen Bld. (GA-06) 65 Bergen Avenue, Newark, NJ 07107</td>
<td>(973) 972-3416</td>
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<tr>
<td></td>
<td>Email: <a href="mailto:wic@umdnj.edu">wic@umdnj.edu</a></td>
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<td>Region</td>
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<tr>
<td>Central</td>
<td>Trinitas WIC Program</td>
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<tr>
<td></td>
<td>40 Parker Road</td>
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<td></td>
<td>Elizabeth, NJ 07208</td>
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<td></td>
<td>(908) 994-5141</td>
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<tr>
<td></td>
<td>Email: <a href="mailto:aotokiti@trinitas.org">aotokiti@trinitas.org</a></td>
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<tr>
<td></td>
<td>Plainfield WIC Program</td>
<td>City of Plainfield</td>
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<tr>
<td></td>
<td>510 Watchung Avenue</td>
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<td></td>
<td>Plainfield, NJ 07060</td>
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<td>(908) 753-3397</td>
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<td></td>
<td>Email: <a href="mailto:prema.achari@plainfieldnj.gov">prema.achari@plainfieldnj.gov</a></td>
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<td></td>
<td>NORWESCAP WIC Program</td>
<td>Hunterdon, Somerset, Sussex and Warren counties (except Franklin Township – see next)</td>
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<tr>
<td></td>
<td>350 Marshall Street</td>
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<td></td>
<td>Phillipsburg, NJ 08865</td>
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<td>(908) 454-1210</td>
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<td>(800) 527-0125</td>
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<td></td>
<td>Email: <a href="mailto:quinnn@norwescap.org">quinnn@norwescap.org</a></td>
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<td></td>
<td>VNA of Central Jersey WIC Program</td>
<td>Middlesex and Monmouth counties and Franklin Township in Somerset County</td>
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<tr>
<td></td>
<td>888 Main Street</td>
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<td></td>
<td>Belford, NJ 07718</td>
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<td>(732) 471-9301</td>
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<td></td>
<td>Email: <a href="mailto:rmcrober@vnacj.org">rmcrober@vnacj.org</a></td>
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<td></td>
<td>The Children’s Home Society of NJ’s Mercer</td>
<td>Mercer County</td>
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<td></td>
<td>WIC Program</td>
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<tr>
<td></td>
<td>80 West Upper Ferry Road</td>
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<tr>
<td></td>
<td>Fisk Professional Center, 2nd Floor</td>
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<tr>
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<td>Ewing, NJ 08628</td>
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<tr>
<td></td>
<td>(609) 498-7755</td>
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<tr>
<td></td>
<td>Website: <a href="http://www.chsofnj.org">www.chsofnj.org</a></td>
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<td>Ocean County WIC Program</td>
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<tr>
<td></td>
<td>175 Sunset Avenue</td>
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<td></td>
<td>P.O. Box 2191</td>
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<td></td>
<td>Toms River, NJ 08754</td>
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<td></td>
<td>(732) 341-9700, ext. 7520</td>
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<td></td>
<td>(800) 342-9738</td>
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<td></td>
<td>Email: <a href="mailto:megmccarthy@ochd.org">megmccarthy@ochd.org</a></td>
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<tr>
<td>Region</td>
<td>Agency Name</td>
<td>Service Area</td>
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</tbody>
</table>
| South  | Atlantic City WIC Program  
City Hall, 1st Floor  
1301 Bacharach Boulevard  
Atlantic City, NJ 08401  
(609) 347-5656  
Email: ttrotman@cityofatlanticcity.org | Atlantic County and Long Beach Island in Ocean County |
|        | Burlington County WIC Program  
Raphael Meadow Health Center  
15 Pioneer Boulevard  
P.O. Box 6000  
Westampton, NJ 08060  
(609) 267-4304  
Email: ddas@co.burlington.nj.us | Burlington County |
|        | Tri-County Community Action Partnership (Gateway CAP)  
10 Washington Street  
Bridgeton, NJ 08302  
(856) 451-5600  
Email: jvelpuri@gatewaycap.org | Camden, Cape, Cumberland, May and Salem counties |
|        | Gloucester County WIC Program  
204 East Holly Avenue  
Sewell, NJ 08080  
(856) 218-4116  
Email: kmahmoud@co.gloucester.nj.us | Gloucester County |

For more details about WIC:
- Call the NJ WIC state office at 1-609-292-9560.
- Call your local WIC agencies at 1-866-446-5942.
Dental Care

Dental care is just as important as your medical care. You should see your dentist at least once every 6 months. (Or at a minimum, once per year.) We encourage you to set up an appointment with your dentist soon after you join our plan. To find a dentist in your area, check your provider directory. You can also search for one using our Find a Provider tool on our website. Go to newjersey.wellcare.com. If you need help making an appointment, Customer Service can help. Call us at 1-888-453-2534 (TTY/TDD 1-877-247-6272).

If you need a service and it sounds more medical than dental, ask your PCP or dental provider. (For example, if you need surgery for a fractured jaw.) He or she will be able to explain the difference to you. He or she can tell you if the service requires prior authorization too.

Family Planning

Family planning services are available to you too. Some of the covered services include:

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

You can choose where to get these services. You just need your WellCare ID card. Pick a provider from our network by looking through our provider directory or calling Customer Service. Call 1-888-453-2534 (TTY/TDD 1-877-247-6272). Or, you can use your Medicaid card if you want to see a provider who’s not in our network.

NJ FamilyCare D members must get these services from one of our providers. (You cannot go through Medicaid.) There are exceptions for certain members. Please call Customer Service at 1-888-453-2534 (TTY/TDD 1-877-247-6272) to learn more.
Mental Health Care – DDD Members Only

We provide mental health services to those members in NJ’s Division of Developmental Disabilities (DDD) program. (Partial care and partial hospitalization are covered by Medicaid.)

If at any time you feel you need mental health care, we are here to help. (This includes mental health services at a hospital and substance abuse care.) We have several ways to help you find a mental health provider.

- By using our Find a Provider search tool on our website (newjersey.wellcare.com).
- Look through your provider directory.
- Give us a call at 1-888-453-2534 (TTY/TDD 1-877-247-6272) and we will help you find and choose a provider.

What to Do if You Need Help

Call us if you experience any of the following. We’ll give you the names and phone numbers of providers who can help.

- Always feeling sad
- Feeling hopeless and/or helpless
- Feelings of guilt or worthlessness
- Problems sleeping
- No appetite
- Weight loss or gain
- Loss of interest in the things you like
- Problems paying attention
- Being upset
- Your head, stomach or back hurts, and your doctor hasn’t found a cause
- Drug or alcohol problems

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

Do you think your health is at risk? Do you feel you are a danger to yourself or others? If you do, call 9-1-1 or go to the nearest hospital. You do not need pre-approval for a mental health emergency.

The doctor who treats you may feel you need more care after your emergency visit. He or she may feel this care could stabilize, improve or resolve your health problem. We will cover this post-stabilization care. Remember to follow up with your PCP within 24 to 48 hours after you leave the hospital.

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

Make sure to read the Emergency Care section of this handbook for more information about what to do in an emergency.
Mental Health Care – Non-DDD Members

If you are not in the DDD program, you will get your mental health and substance abuse care through Medicaid. You don’t need a referral from your PCP to see a mental health provider.

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

• Call your PCP
• You can also call the NJ Division of Mental Health at 1-800-382-6717 (TTY/TDD 1-877-294-4356)

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

• Call the Office of Child Behavioral Health at 1-877-652-7624 (TTY/TDD 1-877-294-4356)

Our Customer Service team can help too. Call us at 1-888-453-2534 (TTY/TDD 1-877-247-6272). (The mental health/substance abuse care you get is based on your NJ FamilyCare Program plan.) One of our reps will help to answer any questions you may have about these services.

Prescriptions

Prescriptions must be written by one of our network providers. Once you have your prescription, go to any network pharmacy to get it filled. Our provider directory lists all of the pharmacies that accept our plan. You can search for one using our Find a Provider search tool on our website. Customer Service can help you find one too.

At the pharmacy, you’ll need to show your WellCare ID card to pick up your prescription. Some drugs and over-the-counter drugs that we cover may have a co-pay. Please see the Services Covered by WellCare section for more information.

Don’t forget to ask your provider and pharmacist about generic drugs. These work the same as brand-name drugs (and have the same active ingredients). But they cost less. This can help to lower your co-pay (if you have one). (Sometimes, your provider may have to ask us to approve a brand-name drug when a generic is available because the brand-name is medically necessary for you.)
 Preferred Drug List
We have a Preferred Drug List or PDL for short. (It’s sometimes called a formulary.) This is a list of drugs that has been put together by doctors and pharmacists. Our network providers use this list when they prescribe a drug for you. To see our PDL, go to our website at newjersey.wellcare.com.

The PDL will include drugs that may have limits, like:

- Prior authorization
- Quantity limits
- Step therapy
- Age or gender limits

For those drugs that require prior authorization (and those not on our PDL), your provider will need to send us a Coverage Determination Request (CDR). We will also allow a pharmacy to give you a 72-hour supply of any drug (on or not on our PDL) that needs a prior authorization.

There are some medications we will not cover. They include:

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

Can I get any drug I want?
You will get all drugs that are medically necessary. All drugs your providers prescribe for you may be covered if they are on our PDL. You may have to get pre-approval if your provider prescribes certain drugs. (This includes drugs for mental health and substance abuse treatment.) In some cases, we may require you to try another drug before approving the one originally requested. We may not approve your requested drug if you do not try the alternative drug first.
Over-the-Counter (OTC) Drugs
You can get some OTC drugs at the pharmacy with a prescription. Some of the OTC drugs we cover include:

- Diphenhydramine
- Meclizine
- H2 receptor antagonists
- Ibuprofen
- Multi-vitamins/multi-vitamins with iron
- Insulin
- Insulin syringes
- Non-sedating antihistamines
- Iron
- Topical antifungals
- Urine test strips
- Coated aspirin
- Antacids
- Proton pump inhibitors

Pharmacy Lock-In
You may see a number of different doctors for your care. And each doctor may prescribe a different drug for you, which can sometimes be dangerous. So to help with this, we have a Pharmacy Lock-In program.

The program helps to coordinate your drug and medical care needs. Here’s how it works:

- You would get all of your prescriptions from one pharmacy.
- This will help the pharmacist to understand your prescription needs.
- If your assigned pharmacy does not immediately have your medication, you’ll be able to get a 72-hour emergency supply at another pharmacy.

If we feel you would benefit from this program, we may “lock you into” one pharmacy. We’ll send you a letter to let you know if you will be locked in. We’ll also let your PCP and pharmacy know. If you do not agree with the lock-in, you can file an appeal with us. (Keep reading for the Member Complaints, Grievances and Appeals Procedures section later in this handbook.)

For questions about our Lock-In program, give us a call at 1-888-453-2534 (TTY/TDD 1-877-247-6272).

Transition of Care
Getting the care you need is very important to us. That’s why we’ll work with you to make sure you get your health care services, whether:

- You’re leaving another health plan and just starting with us
- One of your providers leaves our network
- You leave our plan to go to another one or back to fee-for-service (FFS) Medicaid

Planning Your Care

Here we want to give you information about prevention and planning for your care needs.

Well-Child Care and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services

We have an Early and Periodic Screening, Diagnostic and Treatment program (EPSDT). This program provides needed care for children up to age 21. EPSDT care 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 us
- Regular preventive dental and treatment services, including screening examinations
- Preventive dental treatment (scaling and polishing), following the Academy of Pediatric guidelines
A big part of the EPSDT program is the well-child checkup. This is a checkup your child’s PCP will do to make sure that your child is growing up healthy. During one of these checkups, your child’s PCP will:

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

These well-child checkups are done at certain ages. (We’ll talk about these a little later in this section.) It’s very important that you get your child in to see his or her PCP for these checkups. They can help to find health concerns before they become bigger problems. Also, your child can get his or her needed immunizations.

Best of all, these checkups are done at no cost to you. So make sure to schedule your child’s checkup today. If you need help setting up an appointment, call Customer Service at 1-888-453-2534 (TTY/TDD 1-877-247-6272). And don’t forget, if you need to cancel the appointment, reschedule it as soon as you can.

**Preventive Health Guidelines**

The following are guidelines for preventive care. We’ve provided these to you to help you remember to see your PCP. Your PCP will tell you when you and your family are due for your checkups. He or she will also remind you when you and your family need certain screenings and immunizations.

Please remember – these are suggested guidelines. They do not replace your PCP’s judgment. You should always talk with your PCP about the care that’s right for you and your family.
Adult Preventive Health Guidelines

If you are a new WellCare member, you should get a baseline physical exam and dental exam within the first 90 days of joining our plan. If you’re pregnant, you should get this done within 3 days to 3 weeks of joining our plan. (This depends on your risk factors and how long you’ve been pregnant.)

Recommendations for periodic health exam visits for asymptomatic adults are:

- Age 19 to 39 – every 1 to 3 years (women should get an annual Pap smear – if 3 normal smears in a row, then 1 every 3 years)
- 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</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 years of age and older</td>
<td>Blood pressure, height, body mass index (BMI), alcohol use</td>
<td>Each year from age 18 to 21; then, every 1 to 2 years or at your PCP’s recommendation</td>
</tr>
<tr>
<td>Men 35 to 65 years of age</td>
<td>Cholesterol (non-fasting TC/HDL)</td>
<td>Every 5 years (more often if elevated)</td>
</tr>
<tr>
<td>Women 45 to 65 years of age</td>
<td>Cholesterol (non-fasting TC/HDL)</td>
<td>Every 5 years (more often if elevated)</td>
</tr>
<tr>
<td>High-risk men and women 20 years of age and older</td>
<td>Cholesterol (non-fasting TC/HDL)</td>
<td>Every 5 years (more often if elevated)</td>
</tr>
<tr>
<td>Women 18 to 25 years of age who are sexually active (consider at age 12 if sexually active)</td>
<td>Chlamydia</td>
<td>Each year and at your PCP’s recommendation</td>
</tr>
<tr>
<td>Age</td>
<td>Screening</td>
<td>Timing</td>
</tr>
<tr>
<td>----------------------------</td>
<td>----------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Women 18 to 65 years of age (or 3 years after onset of sexual activity, whichever comes first)</td>
<td>Pap smear</td>
<td>Every 1 to 3 years</td>
</tr>
<tr>
<td>Women 35 to 39 years of age</td>
<td>Baseline mammography</td>
<td>First-time screening</td>
</tr>
<tr>
<td>Women 40 years of age and older</td>
<td>Mammography</td>
<td>Every year</td>
</tr>
<tr>
<td>50 years of age and older</td>
<td>Colorectal (colonoscopy)</td>
<td>Periodically, depending upon test</td>
</tr>
<tr>
<td>Women 65 years of age and older (60 and older if at risk)</td>
<td>Osteoporosis</td>
<td>Bone density test every 2 years</td>
</tr>
<tr>
<td>65 years of age and older</td>
<td>Vision, hearing</td>
<td>Periodically</td>
</tr>
</tbody>
</table>

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

These guidelines are recommendations only. Other services may be needed.

<table>
<thead>
<tr>
<th>Age</th>
<th>Screening and Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn</td>
<td>Well-baby* checkup at birth</td>
</tr>
<tr>
<td></td>
<td>Hearing test</td>
</tr>
<tr>
<td></td>
<td>Newborn screening blood tests</td>
</tr>
<tr>
<td>2–4 days</td>
<td>Well-baby checkup if discharged less than 48 hours after deliver</td>
</tr>
<tr>
<td></td>
<td>Newborn screening blood tests</td>
</tr>
<tr>
<td>1 month</td>
<td>Well-baby checkup</td>
</tr>
<tr>
<td></td>
<td>Newborn screening blood test if not already completed</td>
</tr>
<tr>
<td>2 months</td>
<td>Well-baby checkup</td>
</tr>
<tr>
<td></td>
<td>Newborn screening blood test if not already completed</td>
</tr>
<tr>
<td>4 months</td>
<td>Well-baby checkup</td>
</tr>
<tr>
<td>6 months</td>
<td>Well-baby checkup</td>
</tr>
<tr>
<td>Age</td>
<td>Screening and Timing</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>9 months</td>
<td>Well-baby checkup</td>
</tr>
<tr>
<td></td>
<td>Lab testing: blood lead</td>
</tr>
<tr>
<td>12 months</td>
<td>Well-baby checkup</td>
</tr>
<tr>
<td>(1 year)</td>
<td>Lab testing: blood lead, hemoglobin or hematocrit</td>
</tr>
<tr>
<td></td>
<td>Dental visit as needed</td>
</tr>
<tr>
<td>15 months</td>
<td>Well-baby checkup</td>
</tr>
<tr>
<td></td>
<td>Lab testing: urine and blood lead if not done at 9 months or 12 months</td>
</tr>
<tr>
<td>18 months</td>
<td>Well-baby checkup</td>
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<tr>
<td></td>
<td>Dental visit</td>
</tr>
<tr>
<td>24 months</td>
<td>Well-baby checkup</td>
</tr>
<tr>
<td>(2 years)</td>
<td>Lab testing: blood lead</td>
</tr>
<tr>
<td>30 months</td>
<td>Well-baby checkup</td>
</tr>
<tr>
<td>3 years</td>
<td>Well-child* checkup</td>
</tr>
<tr>
<td></td>
<td>Eye screening</td>
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<tr>
<td>4 and 5 years</td>
<td>Well-child checkup each year</td>
</tr>
<tr>
<td></td>
<td>Eye screening</td>
</tr>
<tr>
<td></td>
<td>Lab testing: urine test at age 5 years</td>
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<tr>
<td></td>
<td>Dental visit twice a year</td>
</tr>
<tr>
<td>6–10 years</td>
<td>Well-child checkup each year</td>
</tr>
<tr>
<td></td>
<td>Dental visit twice a year</td>
</tr>
<tr>
<td>11 and 12 years</td>
<td>Well-child checkup each year</td>
</tr>
<tr>
<td></td>
<td>Dental visit twice a year</td>
</tr>
<tr>
<td>13–21 years</td>
<td>Well-adolescent* checkup every year</td>
</tr>
<tr>
<td></td>
<td>Females should have a pelvic exam and Pap smear between ages 18 and 21 years</td>
</tr>
<tr>
<td></td>
<td>Lab testing: urine by age 16</td>
</tr>
</tbody>
</table>

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

**Dental visits may be recommended beginning at age 6 months.
The following services are provided as needed:

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

Legal Disclaimer: Preventive health guidelines are based on guidelines from third parties available before printing. These guidelines are not a replacement for your doctor’s medical advice. He/She may have more current details. You should always talk with your doctor(s) about what care and treatment is right for you. The fact that a service or item is in these guidelines is not a guarantee of coverage or payment. Members should look at their own plan coverage papers to see what is or is not a covered benefit. WellCare does not offer medical advice or provide medical care, and does not guarantee any results or outcomes. WellCare does not warrant or guarantee, and shall not be liable for:

• Information in these guidelines
• Information not in these guidelines
• Any recommendations made by independent third parties from whom any of the information was obtained

Version: 05/2011 (revised)
### 2013 Recommended Immunizations for Children from Birth Through 6 Years Old

<table>
<thead>
<tr>
<th>Age</th>
<th>HepB</th>
<th>RV</th>
<th>DTaP</th>
<th>Hib</th>
<th>PCV</th>
<th>IPV</th>
<th>Influenza</th>
<th>MMR</th>
<th>Varicella</th>
<th>HepA§</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth</td>
<td>HepB</td>
<td>RV</td>
<td>DTaP</td>
<td>Hib</td>
<td>PCV</td>
<td>IPV</td>
<td></td>
<td>MMR</td>
<td>Varicella</td>
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<tr>
<td>1 month</td>
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<tr>
<td>2 months</td>
<td>HepB</td>
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<tr>
<td>4 months</td>
<td>RV</td>
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<tr>
<td>12 months</td>
<td>DTaP</td>
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<tr>
<td>18 months</td>
<td>DTaP</td>
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<td>19–23 months</td>
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<td>2–3 years</td>
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<td>4–6 years</td>
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</tbody>
</table>

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

**FOOTNOTES:**

* Two doses given at least four weeks apart are recommended for children aged 6 months through 8 years of age who are getting a flu vaccine for the first time and for some other children in this age group.

§ Two doses of HepA vaccine are needed for lasting protection. The first dose of HepA vaccine should be given between 12 months and 23 months of age. The second dose should be given 6 to 18 months later. HepA vaccination may be given to any child 12 months and older to protect against HepA. Children and adolescents who did not receive the HepA vaccine and are at high-risk, should be vaccinated against HepA.

If your child has any medical conditions that put him at risk for infection or is traveling outside the United States, talk to your child's doctor about additional vaccines that he may need.

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

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

AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
## Vaccine-Preventable Diseases and the Vaccines that Prevent Them

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

* DTaP combines protection against diphtheria, tetanus, and pertussis.
** MMR combines protection against measles, mumps, and rubella.
# 2013 Recommended Immunizations for Children from 7 Through 18 Years Old

## 7–10 YEARS
- Tdap
- MCV4

## 11–12 YEARS
- Tdap
- Human Papillomavirus (HPV) Vaccine (3 Doses)
- Meningococcal Conjugate Vaccine (MCV4) Dose 1

## 13–18 YEARS
- Tdap
- HPV
- MCV4 Dose 1
- Booster at age 16 years

### Footnotes
1. Tdap vaccine is combination vaccine that is recommended at age 11 or 12 to protect against tetanus, diphtheria and pertussis. If your child has not received any or all of the DTaP vaccine series, or if you don't know if your child has received these shots, your child needs a single dose of Tdap when they are 7 -10 years old. Talk to your child’s health care provider to find out if they need additional catch-up vaccines.

2. All 11 or 12 year olds – both girls and boys – should receive 3 doses of HPV vaccine to protect against HPV-related disease. Either HPV vaccine (Cervarix® or Gardasil®) can be given to girls and young women; only one HPV vaccine (Gardasil®) can be given to boys and young men.

3. Meningococcal conjugate vaccine (MCV) is recommended at age 11 or 12. A booster shot is recommended at age 16. Teens who received MCV for the first time at age 13 through 15 years will need a one-time booster dose between the ages of 16 and 18 years. If your teenager missed getting the vaccine altogether, ask their health care provider about getting it now, especially if your teenager is about to move into a college dorm or military barracks.

4. Everyone 6 months of age and older—including preteens and teens—should get a flu vaccine every year. Children under the age of 9 years may require more than one dose. Talk to your child's health care provider to find out if they need more than one dose.

5. A single dose of Pneumococcal Conjugate Vaccine (PCV13) is recommended for children who are 6–18 years old with certain medical conditions that place them at high risk. Talk to your healthcare provider about pneumococcal vaccine and what factors may place your child at high risk for pneumococcal disease.

6. Hepatitis A vaccination is recommended for older children with certain medical conditions that place them at high risk. HepA vaccine is licensed, safe, and effective for all children of all ages. Even if your child is not at high risk, you may decide you want your child protected against HepA. Talk to your healthcare provider about HepA vaccine and what factors may place your child at high risk for HepA.

For more information, call toll free 1-800-CDC-INFO (1-800-232-4636) or visit http://www.cdc.gov/vaccines/teens
Vaccine-Preventable Diseases and the Vaccines that Prevent Them

Diphtheria (Can be prevented by Tdap vaccine)
Diphtheria is a very contagious bacterial disease that affects the respiratory system, including the lungs. Diphtheria bacteria can be passed from person to person by direct contact with droplets from an infected person’s cough or sneeze. When people are infected, the diphtheria bacteria produce a toxin (poison) in the body that can cause weakness, sore throat, low-grade fever, and swollen glands in the neck. Effects from this toxin can also lead to swelling of the heart muscle and, in some cases, heart failure. In severe cases, the illness can cause coma, paralysis, and even death.

Hepatitis A (Can be prevented by HepA vaccine)
Hepatitis A is an infection in the liver caused by hepatitis A virus. The virus is spread primarily person-to-person through the fecal-oral route. In other words, the virus is taken in by mouth from contact with objects, food, or drinks contaminated by the feces (stool) of an infected person. Symptoms include fever, tiredness, loss of appetite, nausea, abdominal discomfort, dark urine, and jaundice (yellowing of the skin and eyes). An infected person may have no symptoms, may have mild illness for a week or two, or may have severe illness for several months that requires hospitalization. In the U.S., about 100 people a year die from hepatitis A.

Diphtheria (Can be prevented by Tdap vaccine)
Diphtheria is a very contagious bacterial disease that affects the respiratory system, including the lungs. Diphtheria bacteria can be passed from person to person by direct contact with droplets from an infected person’s cough or sneeze. When people are infected, the diphtheria bacteria produce a toxin (poison) in the body that can cause weakness, sore throat, low-grade fever, and swollen glands in the neck. Effects from this toxin can also lead to swelling of the heart muscle and, in some cases, heart failure. In severe cases, the illness can cause coma, paralysis, and even death.

Hepatitis B (Can be prevented by HepB vaccine)
Hepatitis B is an infection of the liver caused by hepatitis B virus. The virus spreads through exchange of blood or other body fluids, for example, from sharing personal items, such as razors or during sex. Hepatitis B causes a flu-like illness with loss of appetite, nausea, vomiting, rash, joint pain, and jaundice. The virus stays in the liver of some people for the rest of their lives and can result in severe liver diseases, including fatal cancer.

Human Papillomavirus (Can be prevented by HPV vaccine)
Human papillomavirus is a common virus. HPV is most common in people in their teens and early 20s. It is the major cause of cervical cancer in women and genital warts in women and men. The strains of HPV that cause cervical cancer and genital warts are spread during sex.

Influenza (Can be prevented by annual flu vaccine)
Influenza is a highly contagious viral infection of the nose, throat, and lungs. The virus spreads easily through droplets when an infected person coughs or sneezes and can cause mild to severe illness. Typical symptoms include a sudden high fever, chills, a dry cough, headache, runny nose, sore throat, and muscle and joint pain. Extreme fatigue can last from several days to weeks. Influenza may lead to hospitalization or even death, even among previously healthy children.

Measles (Can be prevented by MMR vaccine)
Measles is one of the most contagious viral diseases. Measles virus is spread by direct contact with the airborne respiratory droplets of an infected person. Measles is so contagious that just being in the same room after a person who has measles has already left can result in infection. Symptoms usually include a rash, fever, cough, and red, watery eyes. Fever can persist, rash can last for up to a week, and coughing can last about 10 days. Measles can also cause pneumonia, seizures, brain damage, or death.

Meningococcal Disease (Can be prevented by MCV vaccine)
Meningococcal disease is caused by bacteria and is a leading cause of bacterial meningitis (infection around the brain and spinal cord) in children. The bacteria are spread through the exchange of nose and throat droplets, such as when coughing, sneezing, or kissing. Symptoms include nausea, vomiting, sensitivity to light, confusion and sleepiness. Meningococcal disease also causes blood infections. About one of every ten people who get the disease dies from it. Survivors of meningococcal disease may lose their arms or legs, become deaf, have problems with their nervous systems, become developmentally disabled, or suffer seizures or strokes.

Mumps (Can be prevented by MMR vaccine)
Mumps is an infectious disease caused by the mumps virus, which is spread in the air by a cough or sneeze from an infected person. A child can also get infected with mumps by coming in contact with a contaminated object, like a toy. The mumps virus causes fever, headaches, painful swelling of the salivary glands under the jaw, fever, muscle aches, tiredness, and loss of appetite. Severe complications for children who get mumps are uncommon, but can include meningitis (infection of the covering of the brain and spinal cord), encephalitis (inflammation of the brain), permanent hearing loss, or swelling of the testes, which rarely can lead to sterility in men.

Pertussis (Whooping Cough) (Can be prevented by Tdap vaccine)
Pertussis is caused by bacteria spread through direct contact with respiratory droplets when an infected person coughs or sneezes. In the beginning, symptoms of pertussis are similar to the common cold, including runny nose, sneezing, and cough. After 1-2 weeks, pertussis can cause spells of violent coughing and choking, making it hard to breathe, drink, or eat. This cough can last for weeks. Pertussis is most serious for babies, who can get pneumonia, have seizures, become brain damaged, or even die. About two-thirds of children under 1 year of age who get pertussis must be hospitalized.

Pneumococcal Disease (Can be prevented by Pneumococcal vaccine)
Pneumonia is an infection of the lungs that can be caused by the bacteria called pneumococcus. This bacteria can cause other types of infections too, such as ear infections, sinus infections, meningitis (infection of the covering around the brain and spinal cord), bacteremia and sepsis (blood stream infection). Sinus and ear infections are usually mild and are much more common than the more severe forms of pneumococcal disease. However, in some cases pneumococcal disease can be fatal or result in long-term problems, like brain damage, hearing loss and limb loss. Pneumococcal disease spreads when people cough or sneeze. Many people have the bacteria in their nose or throat at one time or another without being ill—this is known as being a carrier.

Polio (Can be prevented by IPV vaccine)
Polio is caused by a virus that lives in an infected person’s throat and intestines. It spreads through contact with the feces (stool) of an infected person and through droplets from a sneeze or cough. Symptoms typically include sudden fever, sore throat, headache, muscle weakness, and pain. In about 1% of cases, polio can cause paralysis. Among those who are paralyzed, up to 5% of children may die because they become unable to breathe.

Rubella (German Measles) (Can be prevented by MMR vaccine)
Rubella is caused by a virus that is spread through coughing and sneezing. In children rubella usually causes a mild illness with fever, swollen glands, and a rash that lasts about 3 days. Rubella rarely causes serious illness or complications in children, but can be very serious to a baby in the womb. If a pregnant woman is infected, the result to the baby can be devastating, including miscarriage, serious heart defects, mental retardation and loss of hearing and eye sight.

Tetanus (Lockjaw) (Can be prevented by Tdap vaccine)
Tetanus is caused by bacteria found in soil. The bacteria enters the body through a wound, such as a deep cut. When people are infected, the bacteria produce a toxin (poison) in the body that causes serious, painful spasms and stiffness of all muscles in the body. This can lead to “locking” of the jaw so a person cannot open his or her mouth, swallow, or breathe. Complete recovery from tetanus can take months. Three of ten people who get tetanus die from the disease.

Varicella (Chickenpox) (Can be prevented by varicella vaccine)
Chickenpox is caused by the varicella zoster virus. Chickenpox is very contagious and spreads very easily from infected people. The virus can spread from either a cough, sneeze, or it can also spread from the blisters on the skin, either by touching them or by breathing in these viral particles. Typical symptoms of chickenpox include an itchy rash with blisters, tiredness, headache and fever. Chickenpox is usually mild, but it can lead to severe skin infections, pneumonia, encephalitis (brain swelling), or even death.

If you have any questions about your child’s vaccines, talk to your healthcare provider.

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Advance Directives

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

You have the right to choose your own medical care. If you don’t want a certain type of care, you have the right to tell your doctor you don’t want it. To do this, you should complete an advance directive. This is a legal document. It tells others what kind of care you would want if you were not able to communicate it yourself.

There are three types of advance directives:

- A living will
- A health care surrogate for health care decisions
- An anatomical donation

A living will states the kinds of care you want if you are unconscious and cannot wake up. (It can be used for conditions that may lead to death.) It tells your doctor when to continue or stop care to keep you alive.

A health care surrogate for health care decisions is when you name a person you want to make physical and/or mental health decisions for you.

Anatomical donation tells someone you wish to donate all or part of your body at death. This can be an organ donation to someone in need of a transplant. Or it can be a donation of your body to science.

We know that making these kinds of decisions can be hard. And you need to be prepared to answer some
tough questions. Here are some things to consider as you prepare your advance directives:

- It’s your choice to fill one out.
- It is your right, under state law, to make decisions regarding medical care, including the right to accept or refuse medical or surgical treatment.
- Filling one out does not mean you want to commit suicide, physician-assisted suicide, homicide or euthanasia (mercy killing).
- Filling one out will not affect anything that is based on your life or death. For example, other insurance.
- You must be of sound mind to complete one.
- You must be at least 18 years of age or an emancipated (legally-free) minor.
- You must sign it. You will need at least one other person to sign it too.
- After you fill one out, keep it in a safe place. You should give a copy of it to someone in your family and your doctor.
- You can make changes to it at any time.
- A caregiver may not follow your wishes if they go against his or her conscience. If a caregiver cannot follow your wishes, he or she will help you find someone else who can. Otherwise, your wishes should be followed.

To get an advance directive, talk with your PCP. You can also talk with an attorney.
Important Member Information
Member Complaints, Grievances and Appeals Procedures

We want you to let us know right away if you have any questions, complaints or problems with your covered services or the care you receive. If at any point you need help doing this in another language or alternative format, then give us a call. In this section we’ll explain how you can tell us about these concerns/complaints.

State law allows you to make a complaint if you have any problems with us. 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 from our health plan or treat you differently because you made a complaint.

Complaints

A complaint is when you’re not happy with the way you’ve been treated by us or someone who provides a service to you on our behalf. A complaint can also be made if you’re not happy with an action we took or did not take. We must try to resolve the issue within 5 business days or sooner, except when it’s urgent.

Grievances

A grievance is when you make a complaint about us, a provider and/or a service that could not be resolved within 5 business days of receipt. These complaints may be about:

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

You can file a grievance by calling or writing to us. To file by phone, call Customer Service at 1-888-453-2534 (TTY/TDD 1-877-247-6272). To write us, mail to:

WellCare
Attn: Grievance Department
P.O. Box 31384
Tampa, FL 33631-3384
You can file your grievance yourself. Or you can have someone file it for you, including your PCP or another provider. We must have your written permission before someone can file a grievance for you. Your grievance must be filed within 90 days of the event that caused your dissatisfaction.


Within 5 business days of getting your grievance, we will mail you a letter. It’ll tell you we received your grievance. We will make a decision about it within 30 days.

**Utilization Management Appeals**

An appeal is a request you can make when you do not agree with a decision we made about your care. It can also be for when we take too long to make a care decision. You can request an appeal when any of the following actions occur. If we:

- Make a decision that’s not in your favor as part of our Utilization Management (UM) program (see page 42)
- Deny or limit a service (including the type or level of service) you or your doctor asks us to approve
- Deny, limit or stop services you’ve been getting that we already approved
- Deny access to specialty and other care or needed prescription drugs
- Deny a service based on a lack of medical necessity
- Randomly limit medically necessary services
- Deny continuation of care
- Do not pay for the health care services you get (including those that are part of an approved clinical trial)
- Fail to give services in the required timeframe
- Fail to give you a decision on an appeal you already filed in the required timeframe
- Do not agree to let you see a doctor who is not in our network and you live in a rural area or in an area with limited doctors

You will get a letter from us when any of these actions occur. It’s called a “Notice of Action” or “NOA.” You can file an appeal if you do not agree with our decision.
Stage One Appeal

You must file your appeal within 90 days of the date you receive the NOA. You can file your appeal by calling or writing to us. Call 1-888-453-2534 (TTY/TDD 1-877-247-6272). Send your written appeal to:

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

You can file your appeal yourself. Or you can have someone file it for you, including your PCP or another provider. We must have your written permission before someone can file one for you. Our Customer Service team can help you with your appeal too.

We will review your appeal. We’ll send you a decision letter within 72 hours (if it’s an emergency or you’re in the hospital) or 10 calendar days (for all other appeals). You or someone you choose to act for you can review all of the information we used to make our decision.

“Fast” or “ Expedited” Appeals

There may be times when you or your provider will want us to make a faster appeal decision. This could be because you or your provider feels that waiting 10 calendar days could seriously harm your health. If so, you can ask for a “fast” or “expedited” appeal.

You or your provider must call or fax us to ask for a fast appeal. Call Customer Service at 1-888-453-2534 (TTY/TDD 1-877-247-6272). Or fax to 1-877-297-3112. If your appeal request was filed verbally, written notice is not needed.

If we decide you need a fast appeal, we’ll call you with our decision. We’ll also send you a letter with our decision within 72 hours.
If you ask for a fast appeal and we decide that one is not needed, we will:

• Change the appeal to the timeframe for a standard resolution (10 calendar days)
• Make reasonable efforts to call you
• Follow up with a written letter within 2 days of the appeal decision
• Tell you over the phone and in writing that you may file a grievance about the denial of the fast appeal request

Stage Two Appeal
If you disagree with our stage one appeal decision, you can ask for a stage two appeal. You need to do this within 90 days of the date of the stage one denial letter. Your PCP or other provider can request this for you too. To do this:

• Call us at 1-888-453-2534 (TTY/TDD 1-877-247-6272)
• Fax it to 1-877-297-3112
• Send a written request to us at –

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

We will send you a letter within 5 business days of getting your stage two appeal. It will let you know we received your appeal. We will then review your appeal. We’ll send you a decision letter within 72 hours (if it’s an emergency or you’re in the hospital) or 20 business days (for all other appeals). You or someone you choose to act for you can review all of the information we used to make our decision.

Additional Information
You or someone appealing for you can give us more information if you feel it’ll help your appeal. You can do this at any time during the appeal process.
Stage Three Appeal

There’s another step you can take if you are not happy with our stage two appeal decision. It’s called an external appeal. It’s made to an Independent Utilization Review Organization. (Or IURO for short.) If you want an external appeal, you must request it within 4 months of our denial of your stage two appeal. (If WellCare’s denial was for Personal Care Assistant (PCA) services, you cannot use the IURO for a stage three appeal. You must proceed to a Medicaid Fair Hearing for PCA denials. The Medicaid Fair Hearing process is described below.)

As with the other appeal steps, you or your PCP can ask for an external appeal. To do this, follow these steps.

1. Complete an Application for the Independent Health Care Appeals Program (we’ll send it to you with our stage two denial letter)
2. Sign the form (this gives the IURO your permission to review your appeal information)
3. Mail the completed, signed form to:

   New Jersey Department of Banking and Insurance
   Consumer Protection Services
   Office of Managed Care
   20 West State Street, 9th Floor
   P.O. Box 325
   Trenton, NJ 08625-0325

Once the IURO gets your form and appeal information, they will make a decision within 45 days. If you feel waiting 45 days could harm your health, you can call the Department of Banking and Insurance. The number is 1-609-292-7272 or 1-800-446-7467. When you call, ask for a fast review (within 48 hours). (Even if you ask for a fast review, you’ll still need to complete the form mentioned above.)

We will accept the IURO’s decision.
Medicaid Fair Hearings

As a WellCare member, you have the right to a Medicaid Fair Hearing. (This includes all Medicaid, NJ FamilyCare A and some NJ FamilyCare D members. If you are unsure if you’re eligible, please call Customer Service at 1-888-453-2534 (TTY/TDD 1-877-247-6272).)

If you are eligible to request a Medicaid Fair Hearing, you must do so within 20 calendar days (this includes weekends and holidays) of our denial letter. Someone you choose to act for you can ask for one too. Send your written request to:

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

At the hearing, you can represent yourself. You may also have legal counsel, a relative, a friend or other spokesperson represent you. You will explain to a judge from the Office of Administrative Law (OAL) why you feel we made the wrong decision. We will give the reason for our decision too. The judge will listen to both sides. He or she will give his or her opinion to Medicaid. Medicaid will then make its own decision. This can take up to 90 days, unless it’s an urgent request.

If you’re unhappy with the Medicaid Fair Hearing decision, you can appeal to the Appellate Division of Superior Court.

Additional Help

You have the right, at any time, to file a complaint with the New Jersey Department of Banking and Insurance at the following address:

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

Or you can call 1-609-292-7272 or 1-800-446-7467.
You don’t have to request a continuation of benefits during the appeal process. We’ll continue to cover your services during the appeal process up to the Medicaid Fair Hearing (if you are eligible for a Medicaid Fair Hearing), unless:

- You withdraw the appeal; or
- The state hearing office issues a decision against you; or
- The time period or service limits of a previously authorized service have been met

However, you must ask that we continue to cover your medical services during the Medicaid Fair Hearing process. To do this, you:

- Must request the continuation of services within 10 days of the stage 3 appeal denial letter
- Your appeal or request for a Medicaid Fair Hearing involves an action we’re taking to stop or reduce a service we had already approved
- The service was ordered by an authorized provider
- The original time period covered by the approval we gave has not ended yet

If our decision on your appeal or the Medicaid Fair Hearing decision is to deny the service, you may have to pay for the service you received while waiting for the decision.
In this chapter, we will touch on the enrollment and disenrollment processes. If you have any questions, call Customer Service. The number is 1-888-453-2534 (TTY/TDD 1-877-247-6272).

Enrollment
Certain children and adults in the NJ Medicaid program can join our plan. This includes:

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

There are requirements you have to meet to be eligible for Medicaid or SSI.

- For Medicaid, the Division of Medical Assistance and Health Services (DMAHS) will decide eligibility
- For SSI, it’s the Social Security Administration who makes this decision

There is a period of 30 to 45 days between when you complete your Medicaid application and your start date with us. During this time, your Medicaid and managed care eligibility will be verified. (This is done by the DMAHS.) Your health plan membership with us will start the first day of the month after you are approved. If you need health care while this is being done, you will get it through regular fee-for-service (FFS) Medicaid or your current health plan.
Open Enrollment

After you join our plan, you will start a 12-month membership. During the first 90 days (3 months) of your membership, you can try us out. It gives you a chance to decide whether or not to stay with us.

If you decide to change health plans, call the State’s Health Benefits Coordinator (HBC) at 1-800-701-0710 (TTY/TDD 1-800-701-0720). You can call our Customer Service team too. Call 1-888-453-2534 (TTY/TDD 1-877-247-6272).

At the end of 90 days, you’ll stay with us until the State’s Open Enrollment period, which is every year from October 1st to November 15th. You’ll be able to change health plans during that time if you want. The only exception to this is if you have a “good cause” reason to change plans.

You can change health plans each year during the State’s Open Enrollment period of October 1st to November 15th.

Reinstatement

If you lose your Medicaid eligibility but get it back within 60 days, you will be put back in our plan. The State will do this. We will send you a letter within 10 days after you become our member again. You can choose the same PCP you had before or pick a new one.

Moving Out of Our Service Area

If you move out of our service area, call the HBC. The toll-free number is 1-800-701-0710 (TTY/TDD 1-800-701-0720). They’ll help you choose another health plan. You should continue to see our network providers until you are disenrolled from our health plan.

At the end of 90 days, you’ll stay with us until the State’s Open Enrollment period, which is every year from October 1st to November 15th. You’ll be able to change health plans during that time if you want. The only exception to this is if you have a “good cause” reason to change plans.
Involuntary Disenrollment

There are certain reasons you can be disenrolled from our health plan. They can include if you:

- Go into a nursing home for more than 30 days
- Are institutionalized
- Commit fraud, waste or abuse of your health care services
- Act in a disruptive way, and this behavior is not caused by a known illness
- Lose your Medicaid eligibility or can no longer be a member
- Go to jail

You CANNOT be removed from our health plan for these reasons:

- Medical problems you had before becoming our member
- A change in your health
- Reduced mental capacity
- Disruptive behavior because of your special needs
- The amount of services you use
- Missed medical appointments
- Not following your PCP’s plan for your care

Remember:

- Your enrollment and disenrollment with WellCare is subject to the approval of the DMAHS.
- It can take 30 to 45 days for your request to leave our plan to take effect.
- Joining WellCare is your choice.
Important Information about WellCare

In this section, we’ll talk about some of the things we do “behind the scenes.” If you have questions about any of this, please call Customer Service. You can reach us at 1-888-453-2534 (TTY/TDD 1-877-247-6272).

Health Plan Structure, Operations and Provider Incentive Programs

To learn more about the structure and operations of our plan, call Customer Service. Call 1-888-453-2534 (TTY/TDD 1-877-247-6272).

We partner with your providers to make sure you get the right care at the right time. This includes preventive care too. To do this, we will sometimes offer your providers incentives or bonuses. We do this to encourage them to keep you on track with your wellness visits. (Make sure to read the Preventive Health Guidelines section in this handbook. It has all of the wellness visits you should plan for each year.)

How Our Providers Are Paid

We work hard to give you the care you need. We also work with many providers to give you that care. You may sometimes wonder how these providers are paid by us. Or if how they are paid will affect the way they use referrals for care. Or if it will affect other services you may need.

Evaluation of New Technology

We study new technology every year. Plus, we look at the ways we use the technology we already have. We do this for a couple of reasons. They are to:

- Make sure we’re aware of changes in the industry.
- See how new improvements can be used with the services we provide to our members.
- Make sure that our members have fair access to safe and effective care.

We do this review in the following areas:

- Mental health procedures
- Medical devices
- Medical procedures
- Pharmaceuticals
Fraud, Waste and Abuse

Billions of dollars are lost to health care fraud every year. What is health care fraud, waste and abuse? It’s when false data is given on purpose. This can be done by a member or provider. This false data can lead to someone getting a service or benefit that is not allowed.

Here are some other examples of provider and member fraud, waste 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 us or a member
- Waiving patient co-pays or deductibles
- Using someone else’s WellCare ID and/or Medicaid card

If you know of any fraud that has occurred, call our 24-hour fraud hotline. The toll-free number is 1-866-678-8355 (TTY/TDD 1-877-247-6272). It’s also private. You can leave a message without leaving your name. If you do leave a number, we’ll call you back. We’ll call you to make sure the information we have is complete and accurate.

You can also report fraud on our website. Go to newjersey.wellcare.com. Giving a report through the Web is kept private too.
Member Rights

As our member, you have the right to:

- Get information about our plan, services, doctors and other health care providers
- Get information about your rights and responsibilities
- Know the names and titles of the doctors and other health providers caring for you
- Be treated with respect and dignity
- Have your privacy protected
- Choose your PCP from our network of providers
- Decide with your doctor on the care you get
- Have services provided that promote a meaningful quality of life and autonomy, independent living in your home and other community settings as long as it’s medically and socially feasible, and preservation and support of your natural support systems
- Talk openly about the care you need, no matter the cost or benefit coverage, your treatment options and the risks involved (this information must be given in a way you understand)
- Have the benefits, risks and side effects of medications and other treatments explained to you
- Know about your health care needs after you leave your doctor’s office or get out of the hospital
- A second medical opinion
- Refuse care, as long as you agree to be responsible for your decision
- Refuse to take part in any medical research
- File an appeal or grievance about your plan or the care we provide; also, to know that if you do, it will not change how you’re treated
• Not be responsible our debts in the event of bankruptcy and not be held liable for:
  − Covered services provided to you for which the government does not pay us
  − Covered services provided to you for which the government or we do not pay the provider who furnished the services
  − Payments of covered services under a contract, referral or other arrangement to the amount those payments are in excess of the amount you would owe if WellCare provided the services directly

• Be free from hazardous procedures or any form of restraint or seclusion as a means of force, discipline, convenience or revenge

• Ask for and get a copy of your medical records from your doctor; also, to ask that the records be changed/corrected if needed (requests must be received in writing from you or the person you choose to represent you; the records will be provided at no cost; they will be sent within 14 days of receipt of the request)

• Have your records kept private

• Make your health care wishes known through advance directives

• Have a say in our member rights and responsibilities policies and recommend changes to other policies and services we cover

• Appeal medical or administrative decisions by using our appeals and grievances process

• Exercise these rights no matter your sex, age, race, ethnicity, income, education or religion

• Have our staff observe your rights

• Have all of these rights apply to the person legally able to make decisions about your health care

• Be furnished quality services in accordance with 42 CFR 438.206 through 438.210, which include:
  − Accessibility
  − Authorization standards
  − Availability
  − Coverage
  − Coverage outside of network
Member Responsibilities

As our member, you have the responsibility to:

• Read your member handbook to understand how our plan works
• Carry your member ID card at all times
• Give information that we and your doctors and providers need to provide care to you
• Follow plans and instructions for care that you have agreed on with your doctor
• Understand your health problems
• Help set treatment goals that you and your doctor agree to
• Carry your Medicaid card at all times
• Show your member ID card to each provider when you get care
• Schedule appointments for all non-emergency care through your doctor
• Get a referral from your doctor for specialty care
• Cooperate with the people who provide your health care
• Be on time for appointments
• Tell your doctor’s office if you need to cancel or change an appointment
• To pay your co-pays to providers
• Respect the rights and property of all providers
• Respect the rights of other patients
• Not be disruptive at your doctor’s office
• Know the medicines you take, what they are for and how to take them the right way
• Make sure your doctor has copies of all of your previous medical records
• Let us know within 48 hours, or as soon as possible, if you are admitted to the hospital or get emergency room care
• Be responsible for cost sharing only as specified under covered services co-pays
WellCare Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Effective Date of this Privacy Notice: March 29, 2012
Revised as of May 14, 2013

We are required by law to protect the privacy of health information that may reveal your identity. We are also required by law to provide you with a copy of this Privacy Notice which describes our legal duties and health information privacy practices, as well as the rights you have with respect to your health information.

This Privacy Notice applies to the following WellCare entities:

- Easy Choice Health Plan, Inc.
- Exactus Pharmacy Solutions, Inc.
- Harmony Health Plan of Illinois, Inc.
- Harmony Health Plan of Illinois, Inc., d/b/a Harmony Health Plan of Missouri
- Missouri Care, Incorporated
- WellCare Health Insurance of Arizona, Inc., operating as ‘Ohana Health Plan, Inc.
- WellCare Health Insurance of Illinois, Inc.
- WellCare Health Insurance of Illinois, Inc., d/b/a WellCare of Kentucky, Inc.
- WellCare Health Plans of New York, Inc.
- WellCare Health Plans of New Jersey, Inc.
- WellCare of Connecticut, Inc.
- WellCare of Florida, Inc.
- WellCare of Georgia, Inc.
- WellCare of Louisiana, Inc.
- WellCare of New York, Inc.
- WellCare of Ohio, Inc.
- WellCare of South Carolina, Inc.
- WellCare of Texas, Inc., operating in Arizona as WellCare of Arizona, Inc.
- WellCare Prescription Insurance, Inc.

We may change our privacy practices from time to time. If we make any material revisions to this Privacy Notice, we will provide you with a copy of the revised Privacy Notice which will specify the date on which such revised Privacy Notice becomes effective. The revised Privacy Notice will apply to all of your health information from and after the date of the Privacy Notice.
How We May Use and Disclose Your Health Information Without 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. The following are situations where we do not need your written authorization to use your health information or to share it with others.

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, waste and abuse detection and compliance programs, customer service and resolution of internal grievances.

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

3. **Underwriting.** We may use or disclose your health information for certain underwriting purposes. However, we will not use or disclose your genetic information for underwriting purposes.

4. **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.

5. **Business Associates.** We may disclose your health information to a “business associate” that needs the information in order to perform a function or service for our business operations. We will do so only if the business associate signs an agreement to protect the privacy of your health information. Third party administrators, auditors, lawyers, and consultants are some examples of business associates.
2. **Public Need.** We may use your health information, and share it with others, in order to comply with the law or to meet important public needs that are described below:

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

**Requirement for Written Authorization**

We may use your health information for treatment, payment, health care operations or other purposes described in this Privacy Notice. You may also give us written authorization to use your health information or to disclose it to anyone for any purpose. We cannot use or disclose your health information for any reason, except those described in this Privacy Notice, unless you give us a written authorization to do so. For example, we require your written authorization for most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of health information for marketing purposes, and disclosures that constitute a sale of your health information. Marketing is a communication about a product or service that encourages recipients of the communication to purchase or use the product or service.

You may revoke your authorization in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.
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. You also have the right to direct us to send a copy of your EHR to a third party that 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:

(i) is reasonably likely to endanger the life and physical safety of you or someone else as determined by a licensed health care professional;

(ii) refers to another person and a licensed health care professional determines that your access is likely to cause harm to that person; or

(iii) a licensed 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) that 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;
(vii) made to correctional institutions or law enforcement; and
(viii) of an incident related 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 put these restrictions in place except in an emergency situation. We do not need to agree to the restriction unless (i) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and (ii) the health information relates only to a health care item or service that you or someone on your behalf has paid for out of pocket and in full. You have the right to revoke the restriction at any time.

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. 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. You must clearly state in your request that the disclosure of your health information could endanger you and list how or where you wish to receive communications.
6. **Right to Notice of Breach of Unencrypted Health Information.** We are required by law to maintain the privacy of your health information, and to provide you with this Privacy Notice containing our legal duties and privacy practices with respect to your protected 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 this page of this Privacy Notice or visit our Web site at www.wellcare.com.

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**Miscellaneous**

1. **Contact Information.** If you have any questions about this Privacy Notice, you may contact the Privacy Officer at 1-888-240-4946 (TTY/TDD 1-877-247-6272), 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 or take action against you for your complaint.

3. **Additional Rights.** This Privacy Notice explains the rights you have with respect to your health information, including access and amendment rights, under federal law. Some state laws provide even greater rights, including more favorable access and amendment rights, as well as more protection for particularly sensitive information, such as information involving HIV/AIDS, mental health, alcohol and drug abuse, sexually transmitted diseases, and reproductive health. To the extent the law in the state where you reside affords you greater rights than described in this Privacy Notice, we will comply with these laws.
Customer Service: 1-888-453-2534
(TTY/TDD 1-877-247-6272)

newjersey.wellcare.com