
Overview	The Plan will ensure that members are aware of the role of Primary Care Physicians (PCPs), how to obtain care, what to do in an emergency or urgent medical situation and their rights and responsibilities. The Plan will convey this information through various methods including a Member Handbook.
Member Handbook	All newly enrolled members will receive a Member Handbook on or before the member's initial effective date of coverage.
Enrollment	<p>Membership enrollment in WellCare's Medicaid health plans is voluntary as members may select from participating Managed Care Organizations (MCOs) or in the absence of an election, by state-mandated assignment. Eligible Medicaid beneficiaries must enroll in one of the participating MCOs.</p> <p>The Plan accepts a member without consideration of the applicant's health condition, gender, race, religious belief, national origin or handicap.</p> <p>Upon enrollment in the Plan, members are provided with the following:</p> <ul style="list-style-type: none">• Terms and conditions of enrollment;• Description of covered services;• Information about PCPs; such as location, telephone number and office hours;• Information regarding out-of-plan emergency services;• Grievance and disenrollment procedures;• Over-the-counter brochure, if applicable.
Member Identification Cards	Member identification cards are intended to identify Plan members and facilitate their interactions with physicians and other health care providers. Information found on the member identification card may include the member's name, identification number, PCP's name and telephone number, health plan type, contact information and claims filing address.

Possession of the member identification card does not guarantee eligibility or coverage. The physician or provider is responsible for ascertaining the current eligibility of the cardholder.

**Eligibility
Verification**

A member's eligibility status can change at any time. Therefore, all providers should consider requesting and copying a member's identification card, along with additional proof of identification, such as a photo ID, and file them in the patient's medical record.

You may do one of the following to verify eligibility:

- Access the WellCare of Ohio Web site at www.ohio.wellcare.com (contact your Provider Relations representative to schedule a Web site in-service presentation).
- Access WellCare's Interactive Voice Response (IVR) system. You will need your Provider ID number to access member eligibility.
- Contact the Provider Hotline.

Verification is always based on the data available at the time of the request, and since subsequent changes in eligibility may not yet be available, verification of eligibility is not a guarantee of coverage or payment. See your provider agreement for additional details.

**Member Rights and
Responsibilities**

Plan members, adults and children have specific rights and responsibilities. These are included in the Member Handbook.

WellCare members have the right:

- To receive all services that the Managed Care Organization (MCO) is required to provide pursuant to the terms of their provider agreement with the Ohio Department of Job & Family Services (ODJFS).

- To be treated with respect and with due consideration for their dignity and privacy.
- To be ensured of confidential handling of information concerning their diagnoses, treatments, prognoses and medical and social histories.
- To be provided information about their health. Such information should also be made available to the individual legally authorized by the member to have such information, or the person to be notified in the event of an emergency when concern for a member's health makes it inadvisable to give him/her such information.
- To be given the opportunity to participate in decisions involving their health care unless contraindicated.
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- To be assured of auditory and visual privacy during all health care examinations or treatment visits.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To request and receive a copy of their medical records, and to be able to request that their medical records be amended or corrected.
- To be afforded the opportunity to approve or refuse the release of information except when release is required by law.
- To be afforded the opportunity to refuse treatment or therapy. Members who refuse treatment or therapy will be counseled relative to the consequences of their decision

and documentation will be added to the medical record accordingly.

- To be afforded the opportunity to file grievances, appeals or state hearings pursuant to the provisions of rules 5101:3-26-08.4 and 5101:3-26-08.5 of the Administrative Code.
- To be assured that all written member information provided by the MCP is available:
 - At no cost to the member,
 - In the prevalent non-English languages of members in the MCOs service areas,
 - In alternative formats and in a manner that takes into consideration the special needs of members including but not limited to visually-limited and LRP members.
- To be assured that verbal interpretation and verbal translation services are available at no cost to members.
- To be assured that the services of sign language assistance are available to hearing-impaired members.
- To be informed of specific student practitioner roles and the right to refuse student care.
- To refuse to participate in experimental research.
- To formulate advance directives and to file any complaints concerning noncompliance with advance directives with the Ohio Department of Health.
- To change PCPs no less often than monthly. MCOs must mail written confirmation to the member of their new PCP selection prior to or

on the effective date of the change.

- To appeal to or file directly with ODJFS any complaints of discrimination on the basis of race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services in the receipt of health services.
- To be free to exercise their rights and to be assured that exercising their rights does not adversely affect the way the MCO, the MCO's providers, or ODJFS treats the member.
- To be assured that the MCO must comply with all applicable federal and state laws and other laws regarding privacy and confidentiality.
- To choose their health professional to the extent possible and when appropriate.
- To be assured that female members have direct access to a woman's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated PCP, if the PCP is not a woman's health specialist.
- To be provided a second opinion from a qualified health care professional within the MCO's panel. If such a qualified health care professional is not available within the MCO's panel, the MCO must arrange for a second opinion outside the network, at no cost to the member.
- To receive information on their MCO.

Members also have certain responsibilities. These include the responsibility:

- To treat their health care providers and their office staff with courtesy and respect;

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- To fully inform their doctor about their medical problems;
 - To decide about having a medical treatment or procedure before it begins;
 - To help their PCP obtain their medical records;
 - To seek care from a specialist only when given a referral from their PCP, for services that require a referral by WellCare;
 - To seek care in an emergency room for non-life-threatening conditions only after contacting their PCP.
 - To keep all scheduled appointments and be punctual;
 - To follow the rules and regulations of WellCare.

Note: *This information is provided to each Member.*

Medical Necessity

Members will be informed that medically-necessary services are those that are:

- Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible member's medical condition;
- Compatible with the standards of acceptable medical practice in the community;
- Provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and the severity of the symptoms; and
- Not provided solely for the convenience of the member or the convenience of the health care provider or hospital.

**Emergency/
Urgent/Post-
Stabilization
Care**

Emergency services are available to members 24 hours a day, seven days a week to treat an emergency medical condition.

An emergency medical condition shall not be defined or limited based on a list of diagnoses or symptoms. An *emergency medical condition* is a medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious harm to self or others due to an alcohol or drug abuse emergency; or
- Injury to self or bodily harm to others.

Emergency and post-stabilization services do not require prior authorization. Members are instructed, in case of an emergency, to call 911 or proceed to the nearest hospital emergency room. Members should notify their PCP as soon as possible following emergency treatment in order to receive appropriate follow-up care.

Once the member's condition is stabilized, the Plan may require authorization for hospital admission or prior authorization for follow-up care.

WellCare has an Emergency Department diversion program that is described in the **Case Management** section of the Provider Manual.

**Assignment of
Primary Care
Physician**

All Plan members must choose their PCP or they will be assigned to a PCP within the Plan's network. To ensure quality and continuity of care, the PCP is responsible for arranging all of the member's health care needs from providing primary care services to coordinating referrals to specialists and providers of ancillary or hospital services.

However, a PCP referral is not required for behavioral health visits. Behavioral health specialists are responsible for communicating treatment, admissions, discharges and prescribing practices to the member's PCP.

**Changing Primary
Care Physicians**

Members may change their PCP selection at any time by calling Customer Service.