Hawai‘i

Member Handbook

QUEST INTEGRATION

Beyond Healthcare. A Better You.

'ohana health plan™

OhanaHealthPlan.com

ʻOhana Health Plan...

BEYOND HEALTHCARE.
A BETTER YOU.

‘Ohana Health Plan ... Beyond Healthcare. A Better You.

Aloha! Welcome to ‘Ohana Health Plan.

‘Ohana is a managed care plan for QUEST Integration Medicaid members. Many people now get their health benefits through managed care. Managed care plans like ‘Ohana are contracted by the Department of Human Services to help provide quality, cost-effective healthcare. We work with doctors, specialists, hospitals, labs and other healthcare facilities that are a part of our network to provide the benefits offered by Medicaid and to coordinate your healthcare needs. As a member, you may select a primary care provider (PCP). Your PCP will be your personal doctor. They will treat you for most of your healthcare needs and will work with you to direct your healthcare. (For more information on PCPs, see Page 21).

As you work with everyone at ‘Ohana, you will see that we put you and your family first, so you get better healthcare. Our members are our priority. We make every effort to make sure you get the care you need to stay healthy.

This handbook tells you more about your benefits and how your health plan works. Please read it and keep it in a safe place. We hope it answers most of your questions.

For more help, please call Customer Service toll-free at **1-888-846-4262 (TTY 711)** from 7:45 a.m. to 4:30 p.m. Hawai‘i Standard Time (HST). We have friendly staff trained to answer all of your questions. You can also visit us at **www.ohanahealthplan.com**.

We wish you good health!

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We’re Here to Help

We're Here to Help

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

Help from ʻOhana CCS Customer Service

You can call Customer Service toll-free Monday through Friday from 7:45 a.m. to 4:30 p.m. HST.

Call with questions about:

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

You may leave a non-urgent message after hours. We will return your call within one business day.

Customer Service Toll-Free Phone Number
1-888-846-4262 (TTY 711)

You can also contact Customer Service by writing to:
ʻOhana Customer Service
949 Kamokila Blvd.
3rd Floor, Suite 350
Kapolei, HI 96707

@OhanaHealthPlan
www.facebook.com/OhanaHealthPlan

We Protect Your Privacy!

To protect you, when you call Customer Service, we verify your identity. To make changes or access information you will need to tell us your:

- First and last name
- Date of birth
- Address (mailing or residence)

Other ʻOhana Offices	
ʻOhana Health Plan– Maui Office **285 W. Kaʻahumanu Ave.** **Suite 101B** **Kahului, HI 96732**	**ʻOhana Health Plan – Big Island Office** **194 Kilauea Ave.** **Suites 102 and 103** **Hilo, HI 96720**

Our Service Area

'Ohana serves the following areas:

- Kauaʻi
- Molokaʻi
- Lanaʻi
- Oʻahu
- Maui
- Hawaiʻi

If you do not speak English, we can help. We want you to know how to use your healthcare plan no matter what language you speak. Just call us and we will find a way to talk to you in your own language. We have translation services available. We also have information in large print, Braille and audible media. All of these services are available at no cost. Call Customer Service toll-free at **1-888-846-4262**. Our TTY phone number is **711**.

Sometimes, you may want to call a nurse for urgent medical questions. You can call our 24-hour Nurse Advice Line at any time, even after business hours, on holidays or on weekends. A nurse will try to answer your questions and help you when you are not feeling well. Please see the *Nurse Advice Line* section later in this handbook.

Important Phone Numbers

Contact Name	Toll-Free Number
Customer Service	1-888-846-4262 (TTY 711)
24-Hour Nurse Advice Line	1-800-919-8807
Transportation Requests (IntelliRide)	1-866-790-8858
Transportation Ride Assist Line (IntelliRide)	1-866-481-9699
Behavioral Health	1-888-846-4262 (TTY 711)
Dental – Community Case Management Corp. (CCMC)	1-888-792-1070
Vision (Premier)	1-888-846-4262 (TTY 711)
Hearing (HearUSA)	1-888-846-4262 (TTY 711)
Pharmacy	1-888-846-4262 (TTY 711)
Hawaiʻi Med-QUEST Division	1-800-316-8005

Sign In to Your Secure Member Portal on our Website

When you want general information, www.ohanahealthplan.com is the place to go. Visit today to learn about:

- Plan benefits
- Utilization Management guidelines
- Members rights and responsibilities

For more detailed information about YOUR account, sign into the secure member portal on our website to:

- Change your PCP
- Update your address and phone number
- Place your Over-the-Counter order
- Contact your Health Coordinator
- Get a copy of your service plan
- Request to change your Health Coordinator

QUEST Integration Ombudsman Program

The Hawai'i Department of Human Services (DHS) oversees the Medicaid Ombudsman Program. This program lets Koan Risk Solutions, an independent reviewer, look into concerns about Medicaid health plans. Their findings can help health plans reach these goals:

- Making sure you have access to care
- Promoting quality of your care
- Making sure members like you are satisfied with QUEST Integration services

The Ombudsman program is available to all members. You can find out more by contacting Koan Risk Solutions. Their website is **www.himedicaidombudsman.com**. You can also call them at the following phone numbers:

Island	Phone Number
O'ahu	**1-808-746-3324**
Hawai'i	**1-888-488-7988**
Maui and Lana'i	**1-888-488-7988**
Moloka'i	**1-888-488-7988**
Kaua'i	**1-888-488-7988**
Email: **hiombudsman@koanrisksolutions.com**	**TTY: 711**
O'ahu fax: **1-808-356-1645**	

The Ohana Glossary

WORDS/PHRASES
Abuse: Any practices that are inconsistent with sound fiscal, business or medical practice and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations (including the terms of the RFP, contracts and requirements of state and federal regulations) for healthcare in the managed care setting. Incidents or practices of providers that are inconsistent with professionally recognized standards for healthcare. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.
Acute Care: Short-term medical treatment provided under the direction of a physician, usually in an acute care hospital, for members having an acute illness or injury.
Advance Directive: A legal paper that tells your doctor and family how you wish to be cared for when you are ill and need care to prolong life. It goes into effect when you are so ill that you cannot make decisions for yourself.
Appeal: Requests you make when you do not agree with our decision to deny, cut back or end a service. Someone who represents you can also ask for an appeal.
“At-Risk” Services: Some members living at home might need at-risk services to prevent them from worsening.
Authorized Representative: An individual or organization designated by the member, in writing, with the designee’s signature or by legal documentation of authority to act on behalf of a member, in compliance with federal and state law regulations. Designation of an authorized representative may be requested at time of application or at other times as required.
Benefits: Healthcare we cover.
Community Care Services (CCS): For Medicaid members who live with a serious mental health issue.
Co-payment (Co-pay): A specific dollar amount or percentage of the charge identified that a member pays at the time of service to a healthcare plan, physician, hospital or other provider of care for covered services provided to the member.

WORDS/PHRASES

Cost Sharing: How much you must pay when getting care from ʻOhana providers. Your Med-QUEST Division (MQD) eligibility worker will determine this amount.

Disenrollment: When you no longer wish to be a part of our plan, and the steps to follow to leave ʻOhana.

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

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

Emergency Medical Condition: The sudden onset of a medical condition with acute symptoms such as severe pain, psychiatric disturbances, and/or symptoms and substance use that a person could reasonably expect the lack of medical attention might result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to body functions;
3. Serious dysfunction of any bodily functions;
4. Serious harm to self or others due to an alcohol or drug abuse emergency;
5. Injury to self or bodily harm to others; or
6. With respect to a pregnant woman who is having contractions:
   - There is inadequate time for a safe transfer to another hospital before delivery; or
   - That transfer may threaten the health or safety of the woman or her unborn child.

Emergency Medical Transportation: Transportation to a medical provider for conditions that must be treated as soon as possible.

Emergency Room Care: Services received in an emergency room.

Emergency Services: Any covered inpatient and outpatient service by a qualified provider that are needed to evaluate or stabilize an emergency medical condition.

WORDS/PHRASES

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

Excluded Services: Services not covered by your Plan.

EPSDT (Early and Periodic Screening, Diagnostic and Treatment) Comprehensive Visits: Regular health exams for children. The exams are used to find and treat medical problems.

GED® Test: The GED® test is a high school equivalency test. Members who do not have a high school diploma are eligible to take the GED® test at no cost.

Generic Drug: A drug with same basic ingredients as a brand-name drug.

Habilitation: Services and devices that develop, improve or maintain skills and functions for daily living.

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

HiSET® Test: The HiSET® test is a high school equivalency test. Members who do not have a high school diploma are eligible to take the HiSET® test at no cost.

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

Hospice Services: Provides care to terminally ill patients who have a life expectancy of six or fewer months, as determined by their doctor.

Hospitalization: When a person is medically deemed to need care in a hospital. Or the act of admitting a person to the hospital.

Immunizations: Shots that keep a child safe from many serious diseases. There are some shots your child has to get before they can start day care or school in Hawaiʻi.

WORDS/PHRASES

Inpatient: A person who stays in a hospital, usually longer than 24 hours.

Long-Term Services and Supports: Services and help for people who cannot take care of themselves. It may take place at home, in the community or in an institution.

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

Med-QUEST Division (MQD): The offices of the State of Hawaii, Department of Human Services, which oversees, administers, determines eligibility, and provides medical assistance and services for State residents.

Medically Necessary Services: Medical services you need to get well and stay healthy.

Member: A person who has joined our plan.

Network: Healthcare providers who work with an insurance company. Examples of providers include doctors/dentists/pharmacists and clinics/hospitals.

Non-Participating Provider: These healthcare providers are not part of your Plan's network.

Physician Services: Services provided by a provider who is licensed to provide healthcare.

ʻOhana ID Card: An ID card that shows you are a member of our plan.

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

Over-the-Counter (OTC) Drugs: Drugs you can buy that do not require a prescription.

WORDS/PHRASES

Participating Provider – A provider who has a contract with health plans to provide services. Who work with the plan to give healthcare to members. They include Case Managers, agencies, licensed clinical staff, doctors, hospitals, pharmacies, labs and others.

Pharmacy Network: A group of drugstores that members can use.

Plan: A company or its subsidiary that offers insurance coverage.

Post-Stabilization: Follow-up care after you leave the hospital to make sure you get better.

Preferred Drug List (PDL): A selection of medicines approved by ʻOhana doctors and pharmacists in accordance with Hawaiʻi laws and regulations for use by members. These drugs are safe and cost less.

Premium: The cost of insurance coverage.

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

Primary Care Provider (PCP): Your personal doctor or Advanced Practice Registered Nurse. He or she manages all your healthcare needs.

Prior Authorization/Pre-Certification: When we have to OK treatment or medicines ahead of time.

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

Quality Care: Safe, accessible and timely care in the proper setting. Care is coordinated and continuous. It is not periodic.

QUEST Integration: A managed care program. It offers all acute and long-term care services to eligible individuals, families and children under the Medicaid state plan.

Referral: When your PCP sends you to see another healthcare provider.

WORDS/PHRASES

Rehabilitation Services and Devices: This service includes physical and occupational therapy, audiology, and speech language pathology. Services are limited to those who are expected to improve in a reasonable amount of time.

Skilled Nursing Care: A licensed facility that provides appropriate care to persons who: Need assistance with the normal activities of daily living 24 hours a day; Need care provided by licensed nursing personnel and paramedical personnel on a regular, long-term basis; and may have a primary need for skilled nursing care on an extended basis and regular rehabilitation services for 24 hours a day.

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

Treatment: The care you get from doctors and facilities.

Urgent Care: When you require medical care within 24 hours, but the problem will not cause serious harm to your health. You may go to an urgent care center when your PCP cannot see you within 24 hours.

WIC (Women, Infants and Children): A program that helps women, babies and children with nutrition.

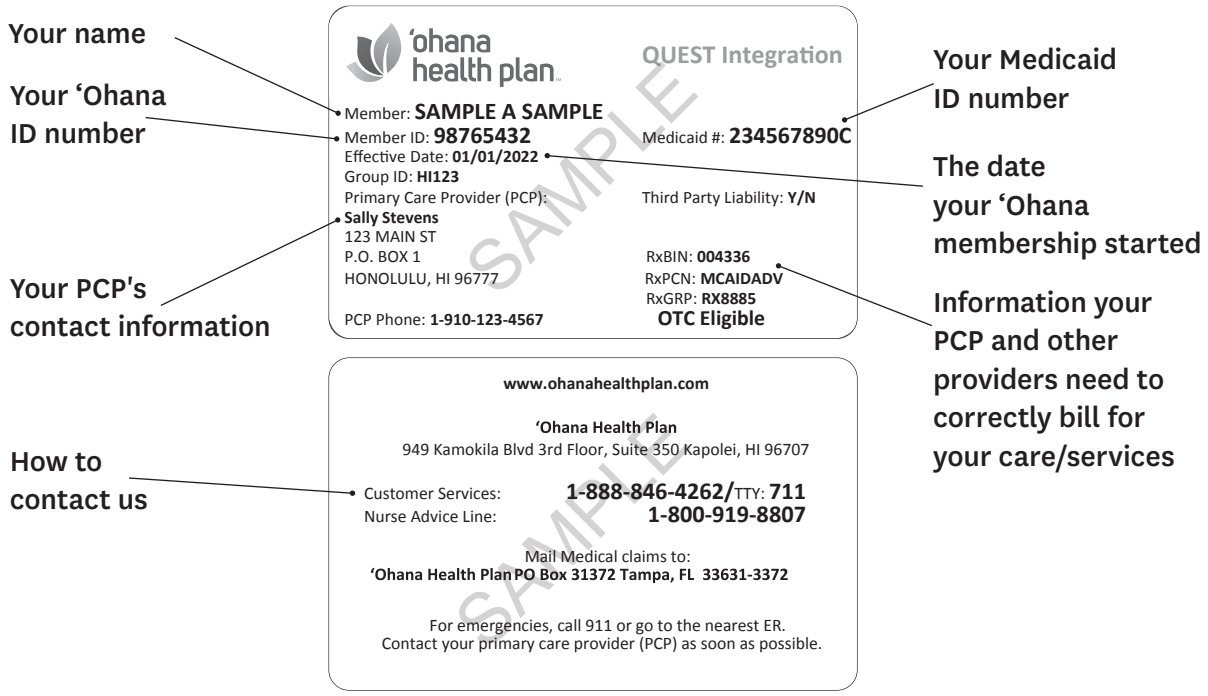
Getting Started With Us

How to Get The Most From Your Plan

Follow these steps and you will be on your way to getting the care you need.

1 Check Your ID Card and Put It in a Safe Place

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



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

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

Call ʻOhana Customer Service as soon as possible if:

- You have not received your card(s) yet
- Any of the information on the card(s) is wrong
- You lose your card(s)

2 Using Your Medicare and QUEST Integration (Medicaid) Benefits

Do you have Medicare? If you do, we can help! Medicare and Medicaid are two different plans that work together. It is important for your doctors and pharmacy to know you have both plans. To make the most out of your coverage, make sure to bring your Original Medicare or Medicare Advantage ID card and your QUEST Integration (Medicaid) ID card to all your medical appointments. Having them will make sure you get the most from your benefits.

If you have Original Medicare, your PCP does not need to be in our network. If you have a Medicare Advantage Plan, then you do not need to choose a PCP for your QUEST Integration plan.

Have Questions?

Our Customer Service agents are knowledgeable with Medicare and Medicaid products. We will help share how these two plans work together.
Call us toll-free at 1-888-846-4262.

3 Choosing Your PCP

You will need to choose a PCP, unless you have Medicare. If you have not done this already, you need to fill out the Member PCP Selection Form. This form came with your new member welcome packet. You have 10 days from the date the letter was received to return the form (not including mail time). You can also call Customer Service or visit us at **www.ohanahealthplan.com** to choose a PCP.

A PCP is assigned to you unless you pick one within 10 days of getting your new member welcome letter. The assignment is based on the following:

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

Do you have Original Medicare or a Medicare Advantage Plan? If so, you do not need to select a PCP for QUEST Integration.

4 Changing Your PCP

You can change your PCP. To do this, go to **www.ohanahealthplan.com**. Or complete the Member PCP Selection Form that came with your new member welcome packet. You can also call Customer Service.

You can change your PCP at any time. If the change is made between the 1st and 10th of the month, it is effective immediately. Changes made after the 10th of the month will become effective the first day of the following month.

We will send you a new ID card after we get the change. Please continue to use your old card to receive services until your new card arrives in the mail. Once you receive your new ID card, make sure the information is correct. Then destroy the old one.

For a list of our PCPs:

- Look in your Provider Directory
- Visit **www.ohanahealthplan.com**
- Call Customer Service

You can learn more about your providers by calling Customer Service. They can tell you about a provider's

schooling or residency, qualifications, or whether they accept new patients. You can also find this information in your Provider Directory.

If you move, call Customer Service. You may want to pick a PCP near your new home. If you move out of our service area, you must call Med-QUEST. The toll-free number is **1-800-316-8005**. They can help you with your healthcare needs.

5 Get to Know Your Primary Care Provider (PCP)

Your PCP is your personal doctor or Advanced Practice Registered Nurse. Call your PCP as soon as possible to schedule a physical. Your PCP will treat you for most of your healthcare needs. Your PCP will work with you to direct your healthcare. They will do your checkups and shots and treat you for most of your healthcare needs. You can reach your PCP by calling their office. Your PCP's name and telephone number may be printed on your ID card.

Your PCP will take care of all your routine medical care. They can arrange specialists, hospital services and behavioral healthcare services.

Our PCPs are trained in different specialties. They include:

- Family and internal medicine
- General practice
- Geriatrics
- Pediatrics
- Obstetrics/Gynecology (OB/GYN)
- Advanced Practiced Registered Nurse services

A specialist can be your PCP, provided:

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

  AND

- The specialist agrees in writing to assume the responsibilities of the PCP

6 How to Get Services Before Choosing or Being Assigned a PCP

You can get services after joining ʻOhana and before you have a PCP. Just look in the Provider Directory that came with this packet. Then select a provider in our network. You can also see a list of providers at **www.ohanahealthplan.com**.

Call to set up an appointment and tell them you are an ʻOhana member. Show them your welcome letter when you arrive for your visit. Your welcome letter has your member ID number and provides proof of your membership with ʻOhana.

If you scheduled an appointment with your PCP and cannot attend, please call your PCP to tell them. The provider won't charge you a "no-show" fee, but it is common courtesy to let them know so they can help you reschedule.

You can also call Customer Service. They help you get the services you need until your ID card arrives with the PCP you have chosen or were assigned.

7 Get to Know Your 24-Hour Nurse Advice Line

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

24-Hour Nurse Advice Line toll-free number: **1-800-919-8807**

When you call, a nurse will ask you some questions about your problem. Tell them as much as you can – where it hurts, what it looks like and what it feels like. They can help you decide if you need to:

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

Call when you need help with problems like:

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

A nurse is there to help. Call the 24-Hour Nurse Advice Line before you call a doctor or go to the hospital when it isn't an emergency.

8 In an Emergency

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

9 Call Us/Tell Us

Questions? Call us. We can get interpreters for all languages. We have materials available in alternate languages, large print, audio tapes and Braille. Sign language services are also available for hearing-impaired members. All of these services are available at no cost. Call toll-free **1-888-846-4262 (TTY 711)** weekdays from 7:45 a.m. to 4:30 p.m. HST.

You may leave a non-urgent message after hours and we will return your call within one business day. You can also contact Customer Service by writing to:

Customer Service
949 Kamokila Blvd.
3rd Floor, Suite 350
Kapolei, HI 96707

You must let us and the Department of Human Services (DHS)/Med-QUEST (MQD) know if:

- You change your name
- You move or change your phone number or address (mailing or residential)
- Your family size changes; for example, if you get married or divorced, have a baby or adopt a child
- Your health status changes; for example, if you become pregnant or are permanently disabled
- You start a new job or your income changes

- You get health insurance from another company
- You are institutionalized; for example, in a State Mental Hospital, Hawaii Youth Correctional Facility, or prison.

10 ʻOhana Members Have Certain Rights and Responsibilities

You have rights as a plan member. You also have certain responsibilities. You can read about these on Page 98.

You now can begin using all of the benefits you get with ʻOhana. We look forward to serving you.

Your Health Plan

Access to Covered Services

Making and Getting to Your Medical Appointments

We have guidelines to make sure you get to your medical appointments in a timely manner. This is also called access to care.

This table gives you an idea of how long it should take to get to a medical appointment:

Provider	Urban	Rural
PCPs, Specialists, OB/GYN, Adult Day Care/Adults Day Health, Hospitals, Emergency Services Facilities, Mental Health Providers, LTSS Providers	30-minute driving time to get to your appointment	60-minute driving time to get to your appointment
Pharmacies	15-minute driving time to get to a network pharmacy	60-minute driving time to get to a network pharmacy
24-hour pharmacy	60-minute driving time to get to a network pharmacy	N/A

How long you should wait for an appointment depends on the kind of care you need. Keep these times in mind as you set your appointments.

Type of Appointment	Type of Care	Appointment Time
Medical	Emergency	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; emergency services outside of the U.S. are not covered)
	Urgent and PCP pediatric sick visits	Within 24 hours (one day)
	PCP adult sick visits	Within 72 hours (three days)
	Routine/Wellness	Within 21 days (three weeks)
	Specialist and non-emergency hospital care	Within four weeks (one month) or of sufficient timeliness to meet Medical Necessity
	Follow-up care after a hospital stay	As needed

Type of Appointment	Type of Care	Appointment Time
Mental Health and Substance Use	Emergency	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; emergency services outside of the U.S. are not covered)
	Routine/Wellness	Within 21 days (three weeks)

Your Financial Responsibilities

Cost Sharing

Members may have to share in the cost of healthcare services. This happens when certain financial eligibility requirements are not met. A Hawai'i eligibility worker will find out your cost-sharing portion. They will tell you and us what it is. If you have a cost-share amount, you must pay your provider or us each month.

These amounts typically are paid to a long-term care facility or home and community-based provider. You may have to pay for services if:

- You see a specialist or other provider without following health plan procedures
- You receive some non-covered services. Please see the non-covered services section for additional details

Covered Services

We have a network of providers to give you the care you need. It includes PCPs, hospitals and other providers. They perform Medicaid-covered services. They include primary, acute, behavioral health and long-term care services. Your provider cannot bill you a "no show" fee. If you schedule an appointment with your PCP and cannot attend, please call your PCP to tell them. While the provider won't charge you a "no- show" fee, it is common courtesy to let them know so they can help you reschedule.

Behavioral Health Services	Coverage and Limits
Inpatient and Outpatient Mental Health and Substance Use	**Covered services include all medically necessary behavioral health services for QUEST Integration members:** • 24-hour-a-day care for acute psychiatric illnesses, including: – Ancillary services – Room and board in an acute hospital – Nursing care – Medical supplies and equipment – Medication management – Diagnostic services – Physician services – Other practitioner services, as needed – Other medically necessary services • Ambulatory services, including 24/7 crisis services • Acute day hospital/partial hospitalization, including: – Medication management – Prescribed drugs – Medical supplies – Diagnostic tests – Therapeutic services, including individual, family and group therapy and aftercare – Other medically necessary services

Behavioral Health Services	Coverage and Limits
Inpatient and Outpatient Mental Health and Substance Use (continued)	• Methadone treatment services, which include the provision of methadone or a suitable alternative (for example, LAAM), as well as outpatient counseling services • Prescribed drugs including medication management and patient counseling • Diagnostic/laboratory services, including: – Psychological testing – Screening for drug and alcohol problems – Other medically necessary diagnostic services • Psychiatric or psychological evaluation • Physician services • Rehabilitation services • Occupational therapy • Other medically necessary therapeutic services *May require prior authorization. See details on page* 72.
Additional Behavioral Health Services	**For members who have a Serious and Persistent Mental Illness (SPMI) and meet the functional eligibility criteria, additional benefits may be available through the Community Care Services (CCS) Program, including:** • Case management • Psychosocial rehabilitation • Clubhouse • Peer support • Supported employment • Partial or intensive outpatient hospitalization *Prior authorization required. See details on page* 72.

Medical Health Services	Coverage and Limits
Acute Inpatient Hospital Care	**Includes the cost of room and board for inpatient stays for:** • Nursing care • Medical supplies • Equipment • Drugs • Diagnostic services • Physical and occupational therapy • Audiology • Speech-language pathology services • All other medically necessary services *May require prior authorization. See details on page* 72.
Adult Day Care	Adult Day Care refers to regular supportive care provided to four or more disabled adult participants. **Services include:** • Observation and supervision by center staff • Coordination of behavioral, medical and social plans and implementation of the instructions as listed in the participant's care plan • Therapeutic, social, educational, recreational, and other activities *Prior authorization required. See details on page* 72.

Medical Health Services	Coverage and Limits
Adult Day Health	**Adult Day Health services are organized day programs for therapeutic, social and health services provided to adults with physical or mental impairments (requires nursing oversight or care). This includes:** · Emergency care · Dietetic services · Occupational therapy · Physical therapy · Physician services · Pharmaceutical services · Psychiatric or psychological services · Recreational and social activities · Social services · Speech-language therapy · Transportation services *Prior authorization required. See details on page* 72.
Assisted Living Services	**Assisted living services include:** · Personal care · Supportive care services (homemaker, chore, attendant services and meal preparation) The health plan is not responsible for payment of room and board *Prior authorization required. See details on page* 72.

Medical Health Services	Coverage and Limits
At-Risk Services	Some ‘Ohana members may not need the same kind of care they would get in a nursing home, but if they don’t get certain additional services, they could end up going into one. Member must live at home and need to meet the “At Risk” criteria. An assessment is completed by your physician or your Health Coordinator. **At-risk services potentially may include:** • Home-delivered meals • Personal Emergency Response System (PERS) • Personal Assistance Level I and II • Adult Day Care • Adult Day Health • Private Duty Nursing Criteria for each of these services and MQD approval must be met to qualify for these services. *Prior authorization required. See details on page* 72.
Cognitive Rehabilitation Services	**Services provided to cognitively impaired persons that assess and treat:** • Communication skills • Cognitive and behavioral ability • Cognitive skills related to performing ADLs Treatment may last up to one year if the member is making progress. Covered services include assessments completed at regular times (determined by the provider and according to the member’s needs). *Prior authorization required. See details on page* 72.

Medical Health Services	Coverage and Limits
Community Care Foster Family Home (CCFFH) Services	**Covered services include:** • Personal care • Homemaker services • Companion services • Day programming • Supportive services • Attendant care • Local transportation • Medication oversight (to the extent permitted under state law) All services must be provided in a certified private home by a principal care provider who lives in the home. *Prior authorization required. See details on page* 72.
Community Care Management Agency (CCMA)	Covered for members living in community care, foster family homes and other community settings, as required. *Prior authorization required. See details on page* 72.

Medical Health Services	Coverage and Limits
Community Integration Services (CIS)	Community Integration Services (CIS) provides case management help to find and maintain housing. Covered for members 18 years or older who are homeless or is at risk of becoming homeless. Members will be assessed to see if he/she meets eligibility criteria. **Services are divided into three categories:** · Pre-Tenancy Services – Screening/assessments; – Develop housing support plan; – Housing search; – Applications prep and submission; – Identify resources/costs for start-up needs; – Identify equipment, technology and other modifications needed; – Ensure housing is safe; – Moving assistance; – Individualized housing crisis plan • **Tenancy Services** – Individual Housing and Tenancy Sustaining Services – Community Transition Services (CTS)

Medical Health Services	Coverage and Limits
Community Integration Services (CIS) (continued)	• Other Housing and Tenancy Support Services – Job skills training/employment activities; – Peer supports; – Non-medical transportation; – Support groups; – Caregiver/family support; – Outreach and in-reach services; – Health management; – Counseling and therapies; – Services assessments; – Service plan development; – Independent living skills/financial literacy; – Equipment, technology and other modifications; – Home management; – Other supplemental services as needed *May require prior authorization. See details on page* 72.

Medical Health Services	Coverage and Limits
Counseling and Training	**Counseling and training activities include:** · Member care training for members · Family and caregivers regarding the nature of the disease and the disease process · Methods of transmission and infection control measures · Biological, psychological care and special treatment needs/regimens · Employer training for consumer-directed services · Use of equipment specified in the service plan · Employer skills updates as necessary to safely maintain the individual at home · Crisis intervention · Supportive counseling · Family therapy · Suicide risk assessments and intervention · Death and dying counseling · Anticipatory grief counseling · Substance use counseling · Nutritional assessment and counseling on coping skills to deal with the stress caused by deteriorating functional, medical, or mental status **Counseling and training is a service provided to:** · Members · Families/caregivers on behalf of the member · Professional and paraprofessional caregivers on behalf of the member *Prior authorization required. See details on page* 72.

Medical Health Services	Coverage and Limits
Dental Services	**Health plan emergency covered services include:** • Dental services performed by a dentist or physician that are needed due to a medical emergency where the services provided are primarily medical. Providing sedation services associated with dental treatment, when performed in an acute care setting, by a physician anesthesiologist. • Dental services in relation to oral or facial trauma, oral pathology (including but not limited to infections of oral origin and cyst and tumor management) and craniofacial reconstructive surgery, performed on an inpatient basis in an acute care hospital setting *May require prior authorization. See details on page* 72. **All other dental services for adults and children are coordinated through Community Case Management Corp. (CCMC) CCMC helps members:** • Find a dentist • Make an appointment • Coordinate transportation and translation services *See "Services Covered by Other Agencies" on page* 58.

Medical Health Services	Coverage and Limits
Dialysis	**Covered services and medical supplies include, but are not limited to:** · Services · Equipment · Supplies · Diagnostic testing · Drugs (medically necessary) Services may be provided as hospital inpatient, hospital outpatient, in a non-hospital renal dialysis facility or in the members' home.
Durable Medical Equipment and Medical Supplies	**Covered services and medical supplies include but not limited to:** · Oxygen tanks and concentrators · Ventilators · Wheelchairs · Crutches and canes · Pacemakers · Incontinence supplies · Orthotic devices · Prosthetic devices · Medical supplies such as surgical dressings and ostomy supplies *May require prior authorization. See details on page* 72.
Early and Periodic Screening Diagnostic and Treatment (EPSDT)	Please see the *Well-Child Care and EPSDT (Early and Periodic Screening, Diagnostic and Treatment) Services* section on page 76 for details on child health checkups.

Medical Health Services	Coverage and Limits
Emergency Services	Covered for medically necessary services. Includes any screening examination services to find out whether an emergency medical condition exists. *Prior authorization is not required.*
Environmental Accessibility Adaptations	**Covered services include:** • Installing ramps and grab-bars • Widening doorways • Modifying bathroom facilities • Installing specialized electric and plumbing systems (must be necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual) • Installing window air conditioning when it is needed for the health and safety of the member **Excluded are changes or improvements to the home that do not have a direct medical or remedial benefit to the member. Changes that would be excluded include:** • Carpeting • Roof repair • Central air conditioning Changes that add square footage to the home also are excluded. All services shall comply with state or local building codes. *Prior authorization required. See details on page* 72.

Medical Health Services	Coverage and Limits
Family Planning Services	**Covers:** • Education and counseling • Emergency contraception • Follow-up • Brief and comprehensive visits • Pregnancy testing • Contraceptive supplies and follow-up care • Diagnosis and treatment of sexually transmitted diseases • Infertility assessment • Sterilization procedures *Family planning does not require a referral from your PCP. Certain procedures may require prior authorization. See details on page 72.* *'Ohana offers family planning services within our network. However, members have freedom of choice. That means you can get these services from providers who are not in our network.*
Fluoride Varnish	Topical fluoride varnish for children 1-6 years old only if they did not receive a topical fluoride treatment in the previous six months

Medical Health Services	Coverage and Limits
Habilitative Services and Devices	**When medically necessary, covered services and devices include:** • Audiology services • Occupational therapy • Physical therapy • Speech/Language therapy • Vision services **Examples may include:** • Augmentative communication devices • Reading devices • Visual aids These are excluded when used specifically for activities at school when Medical Necessity has not been established. Habilitative services do not include coverage for routine vision services. *May require prior authorization – see details on page* 72.
Health Education and Counseling	**Covered services include:** • Substance use including alcohol • Diet and exercise • Injury prevention • Sexual behavior • Dental health • Family violence • Depression • Results and implications of screenings listed above *May require prior authorization. See details on page* 72.

Medical Health Services	Coverage and Limits
Hearing	**Hearing services include:** · Screening · Diagnostic · Corrective services/equipment/supplies **For adults 21 years and older:** · Fitting/Orientation/Hearing aid check (once every 3 years) **For children under age 21:** · Fitting/Orientation/Hearing aid check (two per 3 years) *Prior authorization is required for all hearing aid devices*
Home Health Services	**Some home health services included are:** · Skilled nursing · Home health aides · Medical supplies and durable medical equipment · Physical and occupational therapy · Rehabilitation services · Audiology and speech/language pathology *May require prior authorization. See details on page* 72.

Medical Health Services	Coverage and Limits
Home Maintenance	**Home maintenance services are those services not included as a part of personal assistance and include:** • Heavy-duty cleaning to bring a home up to acceptable standards of cleanliness at the start of service to a member • Minor repairs to essential appliances; limited to stoves, refrigerators and water heaters • Fumigation or extermination services *Prior authorization required. See details on page* 72.
Home-Delivered Meals	Includes nutritious meals delivered where an individual resides (excluding residential or institutional settings). The meals will not replace or substitute for a full day's nutrition (no more than two meals per day). *Prior authorization required. See details on page* 72.
Hospice Services	Provides care to terminally ill patients who have a life expectancy of six or fewer months as determined by their doctor. Medicaid services provided to members who get Medicare hospice services that are the same as Medicare hospice benefits are not covered. Examples include personal care and homemaker services. This is covered only when the service need is not related to the hospice diagnosis. *May require prior authorization. See details on page* 72.

Medical Health Services	Coverage and Limits
Hysterectomies	**Covered under the following requirements:** • At least 21 years of age at the time consent is obtained • The Member is not institutionalized in a correctional facility, mental hospital, or other rehabilitative facility; • Voluntarily chosen by the member (must complete Hysterectomy Acknowledgement Form) • The member has been told orally and in writing the hysterectomy renders the individual permanently incapable of reproducing • The member has signed and dated a Patient's Acknowledgement of Prior Receipt of Hysterectomy Information Form before the hysterectomy • Procedure is medically necessary and is not solely for the purpose of rendering the individual permanently incapable of reproducing • An interpreter is provided when language barriers exist. Arrangements are to be made effectively to communicate the required information to a member who is visually impaired, hearing impaired or otherwise disabled.
Licensed Residential Care	**Residential care is provided in a licensed private home by a principal care provider who lives in the home. They give the following services to members:** • Personal care services • Homemaker, chore, attendant care, companion and nursing services • Medication oversight (to the extent allowed by law) • Transportation to medical appointments

Medical Health Services	Coverage and Limits
Long-Term Care – Institutional Services	Based on your enrollment category as determined by the Department of Human Services (DHS), you may be eligible for these additional benefits *Prior authorization required. See details on page 72.*
Maternity Services	**Covers:** • Prenatal care • Radiology, laboratory and other diagnostic tests • Treatment of missed, threatened and incomplete abortions • Delivery of the infant • Postpartum care • Prenatal vitamins • Lactation counseling (for six months) • Breast pump (rental or purchased for six months) • Inpatient hospital services, physician services, other practitioner services, and outpatient services that impact pregnancy outcomes • 4-day stay after cesarean delivery • 2-day stay after vaginal delivery • Screening, diagnosis, and treatment for pregnancy-related conditions, to include Screening, Brief Intervention, and Referral Treatment (SBIRT), screening for maternal depression, and access to necessary behavioral and substance use treatment or supports • Educational classes on childbirth, breastfeeding, and infant care • Counseling on healthy behaviors

Medical Health Services	Coverage and Limits
Moving Assistance	**Help moving is offered when the Health Coordinator finds that a member needs to move to a new home to keep health from getting worse. This includes:** · Unsafe home due to deterioration · The individual must use a wheelchair, but lives in a building with no elevator · Multistory building with no elevator or where the member lives above the first floor · Home unable to support the member's additional needs for equipment; · Member is evicted from their current living environment; or · The member is no longer able to afford the home because of a rent increase *Moving expenses include packing and moving of belongings.* *Prior authorization required. See details on page* 72.
Nursing Facility Services – Both Intermediate and Skilled Nursing	Covered for members who need 24-hour-a-day help with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). These members need regular, long-term care from licensed nurses and paramedical personnel. Long-term services require MQD approval. **Care is provided in a nursing facility that includes:** · Independent and group activities · Meals and snacks · Housekeeping and laundry services · Nursing and social work services · Nutritional monitoring and counseling · Pharmaceutical services and rehabilitative services *May require prior authorization – see details on page* 72.

Medical Health Services	Coverage and Limits
Other Practitioner Services	**Covered services include but are not limited to:** • Certified nurse midwife services • Licensed advanced practice registered nurse services (including family, pediatric, geriatric, psychiatric health specialists) • Paraprofessionals including peer support specialists • Other medically necessary practitioner services provided by a licensed or certified healthcare provider to include behavioral health providers such as psychologists, marriage and family therapists, mental health counselors, and CSASs when Medical Necessity is established.
Out-of-State and Off-Island Coverage	We provide any medically necessary covered services that are prearranged when not available on your island or in Hawai‘i. **This includes:** • Referrals to an out-of-state or off-island specialist or facility • Transportation to and from the referral destination • Lodging and meals • An adult attendant that the member chooses (if medically necessary and authorized) *May require prior authorization – see details on page* 72.
Outpatient Hospital Care	**This service includes 24/7 care for:** • Emergency services • Ambulatory center services • Urgent care services • Medical supplies • Equipment and drugs • Diagnostic services • Therapeutic services (including chemotherapy and radiation therapy) • Other medically necessary services *May require prior authorization – see details on page* 72.

Medical Health Services	Coverage and Limits
Outpatient Hospital Procedures	**Covered services include:** • Sleep laboratory services and • Surgeries performed in a free-standing ambulatory surgery center (ASC) and in a hospital ASC. *May require prior authorization – see details on page* 72.
Personal Assistance Services – Level 1	May be covered when authorized by the Health Coordinator for members who need help with key daily activities to prevent a decline in health status and keep them in their home. **Services may include:** • Meal preparation • Laundry • Shopping • Errands • Light housekeeping tasks *Prior authorization required. See details on page* 72.

Medical Health Services	Coverage and Limits
Personal Assistance Services – Level 2	Covered for those who need help with daily activities and keeping up their health. This level of service is to be provided by a Home Health Aide (HHA), Personal Care Aide (PCA), Certified Nurse Aide (CNA) or Nurse Aide (NA) with applicable skills. **Some activities include:** • Personal hygiene and grooming, including bathing, skin care, oral hygiene, hair care and dressing • Help with bowel and bladder care • Help with mobility • Help with transfers • Help with medications • Help with routine or maintenance healthcare services by a personal care provider • Help with feeding, nutrition, meal preparation and other dietary activities • Help with exercise, positioning and range of motion • Taking and recording vital signs, including blood pressure • Measuring and recording intake and output, when ordered • Collecting and testing specimens as directed *Prior authorization required. See details on page* 72.

Medical Health Services	Coverage and Limits
Personal Emergency Response Systems (PERS)	**PERS is a 24-hour emergency assistance service that helps members get immediate help in case of an emergency.** • PERS items include electronic devices or services designed for emergency assistance **PERS services are limited to those individuals:** • Who live alone • Who are alone for significant parts of the day • Who have no regular caregiver for extended periods • Who would otherwise need extensive routine supervision • PERS services will only be offered to a member living in a non-licensed setting, except an ALF. *Prior authorization required. See details on page* 72.
Physician Services	**Services must be medically necessary and provided at locations including:** • Physicians' offices • Clinics • Private homes • Licensed hospitals • Licensed skilled nursing facility • Intermediate care facility • Licensed or certified residential setting

Medical Health Services	Coverage and Limits
Podiatry Services	**Covered services include:** • Professional services, not involving surgery, provided in the office or clinic • Professional services, not involving surgery, related to diabetic foot care in an outpatient or inpatient hospital • Surgical procedures involving the ankle and below • Diagnostic radiology procedures limited to the ankle and below • Foot and ankle care related to treatment of infection or injury in the office or an outpatient clinic setting • Bunionectomies are covered only when the bunion is present with overlying skin ulceration or neuroma secondary to the bunion
Post-Stabilization Services	The plan will cover post-stabilization care services at all times, inpatient and outpatient, related to an emergency medical condition after a member is stabilized, to maintain the stabilized condition, or to improve or resolve the member's condition. Post-stabilization services include follow-up outpatient specialist care.
Prescription Drugs	Covers drugs listed on our Preferred Drug List (PDL). This list will also have drugs that may have limits such as prior authorization, quantity limits, step therapy, age limits or gender limits. Alternative drugs may be covered with a prior authorization.

Medical Health Services	Coverage and Limits
Preventive Services	**Services include but are not limited to:** • Initial and interval histories • Comprehensive physical examinations (including developmental services) • Immunizations • Family planning • Diagnostic and screening laboratory • X-ray services (including screening for tuberculosis) *May require prior authorization. See details on page* 72.
Private-Duty Nursing	Covered for those who need ongoing nursing care. The service is provided by licensed nurses within the scope of state law. *Prior authorization required. See details on page* 72.
Radiology/Laboratory/Other Diagnostic Services	**Covered services include:** • Diagnostic • Therapeutic radiology and imaging • Screening and diagnostic laboratory tests *May require prior authorization. See details on page* 72.

Medical Health Services	Coverage and Limits
Rehabilitation Services	**Covered services include:** • Physical and occupational therapy • Audiology and speech/language therapy *May require prior authorization. See details on page* 72.
Respite Care	Respite care is short-term based care. It provides relief to caregivers. It may be provided hourly, daily and overnight. **Respite care may be provided in the following locations (based on current care member is receiving):** • Member's home or place of residence • Foster home or expanded-care adult residential care home • Medicaid-certified nursing facility • Licensed respite day care facility • Other community care residential facility approved by the Plan Respite care services are authorized by the member's PCP as part of the member's care plan. *Prior authorization required. See details on page* 72.
Smoking Cessation	**Covered services include:** • Medication • Counseling • Two quit attempts per benefit period

Medical Health Services	Coverage and Limits
Specialized Medical Equipment Warranty and Supplies	Refers to the purchase, rental, lease, warranty and supplies costs, installation, repairs and removal of devices, controls or appliances that member was already approved for and that was specified in the care plan. **This also includes:** • Items necessary for life support • Supplies and equipment needed for the proper functioning of such items • Durable and non-durable medical equipment not available under the Medicaid state plan **Examples include:** • Specialized infant car seats • Modification of parent-owned motor vehicle to accommodate the child; for example, wheelchair lifts • Intercoms for monitoring the child's room • Shower seat • Portable humidifiers • Electric bills specific to electrical life support devices (ventilator, oxygen concentrator) • Medical supplies *Prior authorization required. See details on page* 72.

Medical Health Services	Coverage and Limits
Sterilizations	**Covered for both men and women if:** • You are at least 21 years of age at the time consent is obtained • You are mentally competent • You voluntarily give informed consent by completing the Informed Consent for Sterilization Form • Your provider completes the Sterilization Required Consent Form *May require prior authorization. See details on page* 72.
Telehealth Services	**Services may include, but are not limited to:** • Real-time video conferencing • Secure interactive and non-interactive web communication, and • Secure transfer of your medical records. Your doctor can use high-quality images and lab reports for your care. **Services not covered include:** • Standard phone calls, faxes or email – in combination or individually – are not considered Telehealth Services • Getting your medication by filling out an online form is not a Telehealth Service If you get in-person care that needs prior approval, you need prior approval to get the same care through Telehealth. Providers will tell you if they provide Telehealth Services. Your provider bills the plan for these services.

Medical Health Services	Coverage and Limits
Transplant Services	Cornea transplants and bone grafts are covered *May require prior authorization. See details on page* 72. Other transplants are covered under the State of Hawai'i Organ and Tissue Transplant Program, not the QUEST Integration program.
Transportation Services	**The plan provides emergency and non-emergency ground and air services to and from medically necessary medical appointments for members who:** • Have no means of transportation • Reside in areas not served by public transportation • Cannot access public transportation due to their medical condition • Do not live in a community foster family home, adult residential care home, expanded adult residential care home, or domiciliary home Transportation is not provided to day programs that are not medically necessary *To learn more about transportation, see page* 65. *May require prior authorization. See details on page* 72.
Urgent Care Services	Covered as medically necessary. Prior authorization may be required.

Medical Health Services	Coverage and Limits
Vision Services	We provide ophthalmologist eye and vision services for members: **Members under age 21** – routine eye exam once every 12 months **Members 21 and older** – routine eye exam once every 24 months More visits and services may be allowed, depending on the symptoms or medical condition. *If prior authorization is approved*. **Covered services include:** • Vision examinations • Cataract removal • Ophthalmologic exam with refraction • Prescription lens • Prosthetic eyes • Visual aids are covered once every 24 months. • Cornea (keratoplasty) transplants **Premier provides this care for you. Call Customer Service to:** • Find a provider • Make an appointment • Coordinate transportation and translation services **New lenses if medically necessary:** • Once every 24 months Replacement glasses and/or new glasses with major changes in prescription are covered within the benefit periods for both adults and children with prior authorization.

Extra Member Benefits

We're excited to offer extra benefits and special programs to our members. To learn more about these or if you have questions, give us a call. Our toll-free number is **1-888-846-4262**. TTY users may call **711**.

General Educational Development (GED®) or Hawai'i HiSET® Exam

We understand the importance of education, which is why we offer this program

- You can take the GED® or HiSET® tests at no charge if you're age 18 or older and don't have your high school diploma
- Visit our website to:
  - Read Frequently Asked Questions (FAQ)
  - Get the registration form
  - Find help preparing for the test

Over-the-Counter (OTC) Supplies

- Get up to $10 worth of products each month per household – that's $120 each year
- You can choose from over 200 items like diapers, pain relievers, reading glasses, dental kits and more
- The items are mailed right to your home

We have three easy ways to order:

1. Call us at **1-888-846-4262 (TTY 711)** to talk to one of our team members
2. Call this same number and use our automated service
3. Go to **www.ohanahealthplan.com** and log in to our member portal

Services Covered by Other Agencies

There may be times when 'Ohana does not cover the services but another agency will. Our trained staff will help you get these services.

Mental Health Services

CAMHD stands for Child and Adolescent Mental Health Division. CAMHD helps children ages 3 to 20. They help families of children with social, emotional and behavioral issues. To get services with CAMHD, please call your local Family Guidance Center. You can use the list below to find the center nearest you. Or you can call your health plan Health Coordinator.

Family Guidance Center	Location	Phone Number
Oʻahu		
Central Oʻahu	Pearl City	**1-808-453-5900**
Family Court Liaison Branch	Kailua	**1-808-266-9922**
Honolulu	Honolulu	**1-808-733-9393**
Leeward Oʻahu	Kapolei	**1-808-692-7700**
Windward Kaneʻohe	Kaneʻohe	**1-808-233-3770**
Hawaiʻi		
Hilo	Hilo	**1-808-933-0610**
Waimea	Kamuela	**1-808-887-8100**
Kailua Kona	Kealakekua	**1-808-322-1541**
Kauaʻi	Lihuʻe	**1-808-274-3883, ext. 231**
Maui		
Wailuku	Wailuku	**1-808-243-1252**
Lahaina	Lahaina	**1-808-662-4045**
Molokaʻi	Kaunakakai	**1-808-553-7878**
Lanaʻi	Lanaʻi City	**1-808-662-4045**

AMHD stands for Adult Mental Health Division. AMHD runs a 24-hour call center called the Crisis Line of Hawaiʻi. When you call the Crisis Line of Hawaiʻi, you can get important information about mental health resources. You also get access to crisis services. You can call the Crisis Line of Hawaiʻi toll-free at **1-800-753-6879**. On Oʻahu, call **1-808-832-3100**.

CCS stands for Community Care Services. This is a behavioral health managed care plan. The plan is for adult members who have Medicaid and a serious and lasting mental illness. Do you think you would benefit from this program? Talk to your mental health provider or health plan Health Coordinator to get a referral to CCS.

Development Disability Waiver Program

Medicaid offers additional services to members with one of the following conditions:

- Developmental disability (DD)
- Intellectual disability (ID)

Contact the Hawai'i Department of Health, Developmental Disabilities Division (DDD). A DDD staff member can check to see if you or your child is eligible. They will help you enroll if you qualify. To contact the DD/ID program, call:

- **1-808-733-1689** in Honolulu, O'ahu
- **1-808-241-3406** in Lihu'e, Kaua'i
- **1-808-243-4625** in Wailuku, Maui
- **1-808-974-4280** in Hilo, Hawai'i

Dental

Some dental services may be covered by the state through the CCMC (Community Case Management Corp.) This includes services for members younger than 21. Med-QUEST (MQD) can help you find a dentist. You can call **1-808-792-1070** in O'ahu. From other islands, call toll-free **1-888-792-1070**.

Transplant

Transplant services may be covered by DHS through the State of Hawai'i Organ and Tissue Transplant (SHOTT) Program. DHS sets limits for transplant coverage. They are limited to non-experimental, non-investigational procedures for the specific organ/tissue and specific medical condition.

We can help with a referral to the SHOTT Program when it is medically appropriate.

Intentional Termination of Pregnancy

Intentional terminations of pregnancy are not covered by 'Ohana. They are covered by the Med-QUEST Division (MQD). You will need authorization. Your provider shall contact MQD's, Clinical Standards Office (CSO), on ITOP request. MQD can also arrange transportation.

Additional Services for Children

Children may qualify for more services with these programs.

- The Early Intervention Program for children with suspected (developmental) delays – call the Early Intervention Program Referral Line toll-free at **1-800-235-5477** (on O'ahu, call **1-808-594-0066**)
- Department of Education (DOE) school-based services — call the DOE at **1-808-586-3230** or **1-808-586-3232**

Women, Infants and Children (WIC) Program

WIC is a special nutrition program. It is for women, infants and children. The program provides:

- Nutrition education
- Nutritious food
- Support for breastfeeding mothers
- Healthcare referrals

Are you pregnant? You can ask your doctor to complete a WIC application. Or you can visit your local health department. You may also call WIC toll-free at **1-808-586-8175**.

Non-Covered Services

You may have to pay for these services. This can happen if:

- You see a specialist or other provider without following health plan procedures
- You receive some non-covered services. Please see the list of non-covered services in the chart for more details

'Ohana is liable only for services authorized by us. A non-covered service might be covered if it is medically necessary.

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

A provider may not bill you for authorized services when they are not paid because they did not follow our procedures. Not paying for services that are not covered will not result in a loss of Medicaid benefits.

Non-Covered Services	Exceptions/Limits
Cosmetic Procedures	Not Covered
Hysterectomies	**Not covered when:** • Performed solely for the purpose of rendering a member permanently incapable of reproducing • There is more than one purpose for performing the hysterectomy (but the primary purpose is to render the member permanently incapable of reproducing) • It is performed for the purpose of cancer prevention
Investigational and Experimental Procedures	Not Covered
Medical Care in a Foreign Country for Children or Adults	Not Covered
Radiology/Laboratory/ Other Diagnostic Services	**Non-covered services include:** • Radiology services – ultrasounds for gender determination **Laboratory and diagnostic services:** • Experimental • Investigational or generally unproven • IgG4 testing • Procedures related to storing, preparation and transfer of oocytes for in vitro fertilization

Non-Covered Services	Exceptions/Limits
Vision Services	**Non-covered services include:** · Orthoptic training · Prescription fee, progress exams · Radial keratotomy, visual training and Lasik procedure · Contacts for cosmetic reasons

Prescription Drug Services

Prescriptions and Pharmacy Access

How do I get a prescription?

'Ohana may pay for any prescriptions from any provider that is not on the Office of Inspector General (OIG) exclusion list, but they do not have to be a participating provider with 'Ohana for us to pay for the member's prescription.

Which drugstores will fill my prescription?

Prescriptions must be filled at a drugstore in our network. A list of these drugstores is in your Provider Directory and at **www.ohanahealthplan.com**. You may also be able to get your prescriptions by 'Ohana's mail-order service. Contact Customer Service to find out about this program.

What is the process for getting a prescription filled?

Show your ID card when you give your prescription to the pharmacist. There is no co-pay for prescribed medications for Medicaid-only members. If a drug is covered under your Medicare Part D benefit, you are responsible for the Part D co-pay. There are certain drugs and over-the-counter medications not covered by Medicare Part D that 'Ohana Health Plan QUEST Integration may cover. Remember to bring your Medicare and/or Medicare Part D and your QUEST Integration member cards to the pharmacy whenever you fill a prescription.

Preferred Drug List

What medicines do we pay for?

'Ohana pays for medicines on our Preferred Drug List (PDL). Doctors and pharmacists make this list. Your doctor will use the list when prescribing drugs for you. Some drugs require approval through a Coverage Determination Request (CDR). This can be done by you, your doctor or an appointed representative. This applies to drugs that have limits such as prior authorization, quantity limits, step therapy, age limits or gender limits and those drugs not listed on the PDL. If you would like to see the list, it is at **www.ohanahealthplan.com**. You can also call Customer Service to ask for a printed PDL to be mailed to you.

Are there medicines we will not pay for?

The plan does not pay for these medicines:

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

Can I get any medicine I want?

You can get all medicines that are medically necessary. All drugs your doctors order may be covered if they are on the Preferred Drug List please see page 62. You may be required to follow prior approval procedures if your doctor prescribes certain medicines. Call Customer Service with any questions. In some cases, you must try another drug before approving the one you originally asked for. We may not approve your requested drug if you do not first try the alternative drug.

Are generic drugs as good as brand-name drugs?

Yes. Generic drugs work the same as brand drugs. They have the same active ingredients as brand drugs.

Other Drugs You Can Get at the Pharmacy

Do we pay for OTC drugs?

As an additional benefit, there are some over-the-counter (OTC) drugs you can get at the pharmacy with a prescription at no cost. Some of these drugs we cover include:

- Aspirin
- Ibuprofen (a pain reliever for headaches, toothaches and back pain)
- Diphenhydramine (for allergy relief)
- Non-sedating antihistamines (allergy relief that won't make you sleepy)
- Insulin
- Insulin syringes
- Urine test strips
- Antacids
- H-2 receptor antagonist (a type of drug that reduces stomach acid)
- Proton pump inhibitors (a type of drug that reduces stomach acid)

- Multivitamins/multivitamins with iron
- Iron
- Topical antifungals
- Meclizine (a type of drug that helps nausea and dizziness)

See our Preferred Drug List for a list of all covered OTC drugs. Call Customer Service with any questions you may have about this.

Direct Member Reimbursement

What is a medication Direct Member Reimbursement?

Sometimes you may pay for medications out of pocket at a retail drugstore. This can happen if you forget to show your ʻOhana QUEST Integration ID card. After such a purchase, you have 36 months to send us a claim form and receipts to recover your costs. This is called Direct Member Reimbursement (DMR). To get a copy of the claim form, call Customer Service toll-free at **1-888-846-4262 (TTY 711)**. We're here for you Monday–Friday from 7:45 a.m. to 4:30 p.m. HST. You can also go to **www.ohanahealthplan.com**.

Where do I send my request?

Send the form to:
ʻOhana Health Plan
Reimbursement Department
P.O. Box 31577
Tampa, FL 33631-3577

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

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

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

How much will I get back?

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

How long should I expect to wait for my reimbursement?

It usually takes 30 days from the date you mail in the DMR form. Be sure your form is completed and has all the information. Otherwise, your request may be delayed or denied. Formulary guidelines will apply to all reimbursement requests.

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

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

Telehealth Services

Do you have trouble getting around? Do you live in a rural part of the state? If so, telehealth services may be for you. This covered plan benefit is just like an in-person doctor visit, but you and your provider are not limited by your locations. You can get the care you need without driving a long distance.

Services may include:

- Real-time video conferencing
- Secure interactive and non-interactive web communication
- Secure transfer of your medical records. Your doctor can use high-quality images and lab reports for your care

Services not covered include:

- Standard phone calls, faxes or email – combined or separate
- Getting your medication by filling out an online form

Any in-person care that needs prior approval will need the same prior approval through Telehealth Services.

Providers will tell you if they offer telehealth services. They will bill us for these services. If you would like to know more about ʻOhana's Telehealth Services, call us toll-free at **1-888-846-4262 (TTY 711)** or visit **www.ohanahealthplan.com**.

Transportation

We will get you where you need to go in an emergency. We also provide non-emergency transportation (NET) services to and from medically necessary appointments for members who:

- Have no means of transportation
- Reside in areas not served by public transportation
- Cannot access public transportation due to their medical condition

When you call for NET services, we will first look for no-cost options. These include:

- The use of your own vehicle
- Family, friends, volunteer services or the facility serving you to provide NET

If these options are not available, we look at another way to meet your NET needs. On Oʻahu, there are three options – taxi, bus and TheHandi-Van services. We arrange for taxi service, or provide you with bus passes or TheHandi-Van passes to get you to appointments. On all other islands, taxi or bus service is used if available.

Bus service is used if:

- Your physical condition allows it (you are able to walk on your own or use a wheelchair);

AND

- If you live less than a half-mile from a bus stop

AND

- If your destination is no more than a half-mile from a bus stop

Taxi service is used:

- If you are physically unable to take the bus (if you are not able to walk on your own and do not use a wheelchair)

OR

- If you live more than a half-mile from a bus stop

OR

- If your destination is more than a half-mile from a bus stop

TheHandi-Van is used:

- If you live on Oʻahu, you may be able to ride TheHandi-Van. This service is for persons with disabilities unable to ride the bus. TheHandi-Van service will be used:
- If your physical condition does not allow you to ride a bus

AND

- You are certified for this service

You must be certified to ride TheHandi-Van.

TheHandi-Van Eligibility Center is at:
The First Insurance Center
1100 Ward Ave.
Suite 835
Honolulu, HI 96814-1613

The center is open Monday through Friday from 8 a.m. to 5 p.m. HST. Please call **1-808-538-0033** to learn more or schedule an in-person interview.

Questions?

- What if your medical provider says you can't ride the bus or TheHandi-Van?
- What if these services aren't available in your area?

We will work with you to find another way to get you where you need to go.

Also talk with your provider about ongoing appointments. They can ask NET for you.

3 steps for using your transportation benefit

1. Schedule a ride by calling IntelliRide toll-free. The number is **1-866-790-8858**. Customer Service can also help.
2. Call at least three business days before your off-island or out-of-state appointment. For ground transportation on your home island, please call IntelliRide at least 48 hours before your appointment. You can schedule a ride as long as 30 days before your appointment.
3. Be ready at least 15 minutes before your pick-up time.

NET service reminders

- NET services are for medical appointments like doctor visits. They are not for trips to the pharmacy, community events or other non-medical trips.
- If you ask for a ride less than 48 hours ahead of time, we may ask you to reschedule if it's not urgent.

Call right away to cancel or reschedule a ride – at least one hour before your pick-up time. This helps give better service for everyone.

What if you're not sure when you will be finished with your appointment? Then please call the Transportation Help Line toll-free at **1-866-481-9699** to make arrangements after your appointment. They will arrive within 90 minutes, so please allow for this time and let them know exactly where to pick you up. This helps the driver find you.

We want to hear from you. If you have a grievance about NET, please call our Customer Service department or call IntelliRide toll-free at **1-866-481-9699** and tell us about your experience.

Pharmacy Lock-In Program

As our valued member, we want you to know about ʻOhana Lock-In Program.

What is the Pharmacy Lock-In Program?

Seeing many different doctors for your care can be dangerous if each doctor prescribes similar drugs for you without knowing what the other one is prescribing. We want you to have a clear understanding of these possible dangers and protect you from that. If we identify that you are in that situation, this program will help you more effectively manage your prescription drug and medical care needs. If you are identified for this program, you will get all of your controlled substance prescriptions from one assigned pharmacy and/or one prescriber. This will help your pharmacist and doctor understand your prescription needs.

Once you are identified and enrolled in this program, you will get a letter from us. We'll also let your doctor and pharmacy know. However, if you do not want to be in the ʻOhana Lock-In Program, you can file an appeal with us. (See the *Member Grievance and Appeals Procedures* section in this handbook.)

- If your assigned pharmacy does not immediately have your medication, you can get a 72-hour emergency supply at another pharmacy as long as your doctor is in our network.

As part of the ʻOhana Lock-In Program, you have access to a Care Team for more support. A Health coordinator can work with you to create an individualized Care Plan. Coordinators provide monitoring,

education, communication and collaboration, and can help with access to other treatments to improve your health. There is no cost to you for this voluntary service.

For questions about our ʻOhana Lock-In Program or to begin working with a Care Team, please call us toll-free at **1-888-846-4262 (TTY 711)** Monday–Friday, from 7:45 a.m. to 4:30 p.m. HST.

Health Coordination

ʻOhana's Health Coordination team helps you better understand your health conditions and how to use your medical plan services. Our Health Coordination teams are led by healthcare professionals, like nurses, social workers and behavioral health specialists. They assess your risk factors, develop an individualized treatment plan, establish treatment goals, monitor outcomes and evaluate the outcome for possible revisions of the care plan.

This program enhances the care you get from your provider. It does not replace any service.

Upon joining ʻOhana Health Plan, you will get a welcome call from our Health Coordination team. This call will help you get the right PCP assigned to your care and identify any cultural needs. They will also make sure you have received your ʻOhana ID card and answer any questions you may have about the information in this handbook. They will also do a screening to see if you should be assigned to a Health Coordinator and identify if you have ongoing special healthcare needs and/or help to help you manage your healthcare needs. You may also be referred to a Disease Management nurse to help you with disease management.

You may be assigned a Health Coordinator if we think you would benefit medically from having one to help arrange, monitor and make sure you get timely care. Health Coordinators work with your PCP to help manage your care. They make sure you have access to needed covered services.

This program may be good for you if you:

- Have a physical, behavioral or developmental condition that needs specialized care
- Have a difficult time managing your health with more than one provider
- Recently left the hospital and need help coordinating your care
- Go to the emergency room or hospital often for care

They will get in touch with you to learn about your:

- Health history
- Existing services

This helps us match you up with the Health Coordinator who best meets your needs.

Then they will call you to set up a face-to-face visit to learn more about your health history.

You can ask to change your Health Coordinator. Just call Customer Service at the phone number listed below. You can also send a written request or send a message through the web.

You can call your Health Coordinator anytime during business hours and leave a message. Regular business hours are Monday-Friday from 7:45 a.m. to 4:30 p.m. HST. Call us toll-free at **1-888-846-4262**. TTY users may call **711**. Your Health Coordinator will return your call within three days.

Sometimes, you may want to call a nurse for urgent medical questions. You can call our 24-hour Nurse Advice Line at any time, even after business hours, on holidays or on weekends. A nurse will help by phone at these times. The nurse may be able to answer many of your questions and help you when you are not feeling well. Please see the *Nurse Advice Line* section in this handbook. This service is at no cost to you. Your provider can also refer you to it at any time. To learn more, please call Customer Service toll-free at **1-888-846-4262** and ask for the Health Coordination team. TTY users may call **711**.

Disease Management

ʻOhana has Disease Management Programs to help you better understand and manage your chronic health condition. The goals of the programs are to:

- Give you disease-specific education and coaching
- Identify barriers to care and develop solutions to those barriers
- Help you better manage your health condition and care needs

Our programs include the following:

- Diabetes mellitus
- Depression
- Asthma
- Coronary Artery Disease

In addition:

- After Hospital Outreach Program (AHOP) for Congestive Heart Failure (CHF)
- Referral to Hawaiʻi Tobacco Quit Line

As an added benefit, any members with these conditions may join this program at no cost. Your Health Coordinator or provider also may refer you to the Disease Management Program. Or you may enroll directly at any time. This program enhances the care you get from your provider. It does not replace any service.

To learn more, call Customer Service toll-free at **1-888-846-4262** and ask for the Disease Management department. TTY users may call **711**.

Behavioral Health Services

We can help you get an outpatient mental health or substance use assessment for you or someone in your family. Call your Health Coordinator or Customer Service to find out more. Our staff will be happy to help you. You do not need prior approval from your PCP.

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

What to Do if You Are Having a Problem

You should call us if you have any of these problems. We can get you an assessment by a behavioral health provider.

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

You do not need to call your PCP for a referral. You may see any in-network behavioral health provider you like without a referral or permission from ʻOhana. If you need help finding a behavioral health provider or wish to see a behavioral health provider not in our network, please call Customer Service for assistance.

What to Do in an Emergency or if You Are Out of Our Service Area

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

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

Behavioral Health Limitations and Exclusions

We will not cover services if they are not medically necessary.

Hospital Services

We can help you get any needed hospital services such as a planned hospital stay or surgery. Emergency services do not require any authorization. See the *Emergency Services* section for more details. For outpatient or inpatient services, your PCP or the specialist will request a prior authorization.

Call Customer Service, check your Provider Directory or visit our website for a list of emergency and post-stabilization service settings.

Other ʻOhana Programs

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

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

How to Get Services

Services That Require a Referral

Your PCP must make a referral for you to get some services. These include:

- Services that your PCP does not perform
- Specialist visits and specialty care at an office or free-standing clinic require a referral

What is a Referral?

A referral is when your PCP sends you to another doctor or facility in our plan to get care. Most often, it will be a specialist. The specialist has extra training in a certain area of medicine. Your PCP will let the specialist or facility know that they are sending you there for treatment. They share your medical records with the specialist or facility.

Services Available Without a Referral (Self-Referral Services)

You do not need approval from your PCP or the plan for these services. Please see the *Covered Services* section for more details about the below services. If you have any questions, please call Customer Service toll-free at 1-888-846-4262. TTY users may call 711.

- Emergency and urgent care services
- Family planning services
- Routine checkups and treatment from your assigned PCP
- Well-child, EPSDT and treatment visits for children younger than the age of 21
- Annual wellness visits for women, including a Pap test
- Lab tests
- Basic X-rays
- Routine vision
- Routine behavioral health outpatient services
- Disease management

You can go to any provider in the ʻOhana network to receive the services listed above.

Just call the provider you choose and set up an appointment. Tell them that you are an ʻOhana member and show them your ID card at your visit.

You can find a list of providers at **www.ohanahealthplan.com**. You can also call Customer Service to ask for a directory.

Services From Providers Not in Our Network

There may be times when the healthcare you need is not available using a provider in our network. If you need care from someone not on our provider list, your PCP will work with the health plan to arrange care for you. Prior authorization may be needed.

Services That Require Prior Authorization/Precertification

We must approve the following services before you can get them. This is called prior authorization or precertification. If you have ongoing special healthcare needs, you have direct access to specialists. However ʻOhana requests a review of the condition. We will give you information about the appeals process and your right to a DHS hearing if you disagree with our decision.

This list may change. Go to www.ohanahealthplan.com or call Customer Service for the most up-to-date list of services that require a prior authorization:

- Certain medical supplies and equipment
- Certain medical procedures done by your PCP or specialist
- Referrals to a case management agency and/or foster home placement
- Referrals or admission to a nursing home or residential home
- Chemotherapy
- Surgical procedures
- Cosmetic procedures
- Non-emergency hospital services
- Any out-of-plan services or non-network care
- Home and community-based services

We will make a decision within 14 days. We may need more time to make this decision. If so, we will then take up to 14 more days. You or your doctor can ask us for a fast decision (a decision made within 72 hours). You may ask for this if waiting for an approval could put your life or health in danger. We sometimes need more time to make a fast decision. This can mean up to an additional 14 business days for us to make a decision or give approval.

Utilization Management Program

We have a utilization management (UM) program. This program looks at the care and services you need. We also look at services that need approval before they can be given. Then we check to see if this is the right care for you before it starts. We complete checks called:

- Prospective reviews – Before you get care, we check to see if you need it
- Concurrent reviews – We look at care while you are getting it to see if you need to keep getting it, and/or if other care would better meet your needs
- Transitional care – We help you with the transition from hospital to home to make sure that you have the medical equipment and services in place before you go home
- Retrospective reviews – We check to see if you needed the care you got, after you received it

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

For all of these types of reviews, there may be times when we say we can't cover services or care that your provider asks for. This may be due to benefit limitations or lack of medical necessity. These decisions may be made by our clinical staff, who are nurses and doctors.

We make sure our reviews are based only on the appropriateness of care and your benefit coverage. They are not based on financial rewards to those who make these decisions.

To learn more about our UM program, please call Customer Service toll-free at **1-888-846-4262 (TTY 711)**.

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

If 'Ohana objects to providing a service on moral or religious grounds, we will notify you within 30 days of adopting the policy. *Please see the Non-Covered Services section for more details on how to access these services*.

Second Medical Opinion

You don't pay for these services. Call your PCP to get a second opinion about your care. You can also call Customer Service for help to arrange a second opinion. They will ask you to pick a network doctor in your area. If you can't find another plan doctor in your area, your PCP will ask you to pick one who is as close to you as possible and in our plan. If no plan doctor is available, your PCP can help you choose one who is not in our plan. Your PCP will get authorization for this visit.

If the second-opinion doctor asks for tests, they must be done by a plan provider.

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

How to Get After-Hours Care

If you get sick or hurt and it is not an emergency, call your PCP. Your PCP's office will direct you on how to get care. If you can't reach your doctor, you may go to an urgent care center.

You can also call the 24-Hour Nurse Advice Line toll-free at **1-800-919-8807**. (See the *Nurse Advice Line* section on page 23.)

Emergency Services

Emergency services are for a serious condition that must be treated right away. This may include inpatient or outpatient services or medical facility services and treatment. (See The 'Ohana Glossary for a definition). We will give you names of providers near you. Call Customer Service, check your Provider Directory or visit our website for listings of emergency and post- stabilization service settings.

What to Do in an Emergency

Call 911 in an emergency. Call an ambulance if you do not have 911 services in your area. Emergency services do not require prior authorization. Go to the nearest hospital, emergency room, or medical facility right away. The choice is yours. Call your PCP or our 24-Hour Nurse Advice Line if you are not sure if it's an emergency. Some examples of emergencies are:

- Sudden heavy blood loss
- Heart attack
- Cuts requiring stitches
- Loss of consciousness
- Poisoning
- Severe chest pains
- When you can't breathe
- Broken bones

An emergency is when the lack of immediate attention results in the following:

- Placing your physical or mental health (or your unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious harm to yourself or others due to an alcohol or drug abuse emergency
- Injury to yourself or bodily harm to others

When you get to the emergency room (ER), you must show your ʻOhana ID card. Let your PCP know as soon as you can when you are in the hospital and let them know that you received care in an ER. We will pay for follow-up care to emergency treatment (post-stabilization).

The ER doctor will decide if your visit is an emergency. If you stay when it is not an emergency, you may have to pay for the care.

You don't need prior approval for emergency services or follow-up care. This is true whether it is within or outside our Hawaiʻi network. Emergency care outside the U.S. is not covered.

Post-Stabilization Services

It's important to get care until your condition is stable. We pay for care you get after your ER care. This is called post-stabilization care. This care is needed to maintain, improve or solve your medical condition.

If you have a question or are unsure about your care, you may contact the provider that treated you while you were in the hospital during regular business hours. If the provider's office is closed, you may call our 24-hour Nurse Advice Line at **1-800-919-8807**.

We pay for care you get after your emergency room care until you are stable or can be safely transferred to an in-network provider to care for you. You do not need preapproval for this care until we feel you are stable to transfer. But this care must be done to maintain, improve or solve your emergency medical condition.

Out-of-Area Emergency Care

What should you do if you have an emergency while traveling within the United States? Go to a hospital. Show your ID card. Call your PCP as soon as you can. Ask the hospital staff to call us. If you have to pay for

care while you are out of the service area, send your claim to our Claims Department. We will need copies of your medical reports and the bills. We also will need proof of payment. You have up to one year to ask to be repaid. You have up to one year to send us your request.

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

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

What to Do if You Need Urgent Care

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

- Injury
- Illness
- Severe pain

Not sure if you need urgent care? Call your PCP or our 24-Hour Nurse Advice Line. Urgent care center services may need prior approval. You must show your ʻOhana and Medicaid ID cards at the urgent care center.

Out-of-State and Off-Island Coverage

We cover any medically necessary covered services that are not available in the state or on the island where you live. If you or your provider decides that you need a service out-of-state or off-island, and it's not available in our plan, just contact us. We work with you to try to find the service locally. We provide these services out-of-state or off-island if we can't find a plan provider.

This includes:

- Referrals to an out-of-state or off-island specialist or facility
- Transportation to and from the referral destination for an off-island or out-of-state destination
- Lodging and meals for you and a needed attendant (if medically necessary)

We work with you to try to get the service locally. We make a decision within 14 days. We may need more time to make this decision. If so, we will then take up to 14 more days. You or your doctor can ask us for a fast decision. This is a decision made within 72 hours. You may ask for this if waiting for an approval could put your life or health in danger. We sometimes need more time to make a fast decision. This can mean up to 14 more business days for us to make a decision or give approval.

What if you get sick or hurt or need medically necessary EPSDT (for members younger than the age of 21) services while you are out of the ʻOhana service area, but it is not an emergency? Then call Customer Service. Call toll-free **1-888-846-4262**. TTY users may call **711**. We help arrange the care you need and ensure you get approval before receiving services.

Pregnancy and Newborn Care

Moms-to-be should set up a visit with an ʻOhana obstetrics (OB) doctor. Do this within 14 days of signing up for the plan or as soon as you find out you are pregnant. Customer Service can help you set up an appointment.

There are more reasons you should call us. We can get you information about having and caring for a baby. We can sign you up for our prenatal programs to make sure you and your baby stay healthy during your pregnancy.

You also must choose a PCP for your baby. You should do this by the time the baby is born. If you have any questions, please call Customer Service toll-free at **1-888-846-4262**. TTY users may call **711**. We are here for you weekdays from 7:45 a.m. to 4:30 p.m. HST.

We cover our members throughout their pregnancy and for the first 30 days after giving birth. The DHS will contact you to tell you of the health plan choices for your baby. You will have 15 days to choose a plan. If your baby is eligible for QUEST Integration and you do not choose within 30 days, your baby is assigned to ʻOhana.

Transition of Care

ʻOhana Health Plan is here to help. If you are new to ʻOhana or your PCP is no longer participating with ʻOhana, we can work with you and your PCP to continue to receive services as we transition you to a participating provider.

If you are leaving ʻOhana, we can help with your transition.

Please call Customer Service to help arrange the transition you need.

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

ʻOhana has an EPSDT program. It stands for Early and Periodic Screening, Diagnostic and Treatment. It provides needed care for members younger than the age of 21. EPSDT care may include services like:

- Preventive care for members from newborn through age 20
- Services and medications
- Lab tests (as needed)
- Prescriptions (as needed)
- 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
- Intensive Behavioral Therapies (for example, Applied Behavioral Analysis (ABA) services for members with an Autism Spectrum Disorder (ASD) diagnosis
- Any needed services as part of a treatment plan that is approved as medically necessary by the plan
- Regular preventive dental and treatment services, including screening examinations, prophylactic treatment (scaling and polishing), following the Academy of Pediatric guidelines

With our EPSDT Program, children may be able to get additional Medicaid services. To learn more, call Customer Service toll-free at **1-888-846-4262**. TTY users may call **711**.

What is a well-child checkup?

A well-child checkup is when your child's PCP checks to make sure that your child is growing up healthy. The PCP will:

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

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

Why is the well-child checkup important?

Checkups help find health concerns before they become bigger problems. Also your child can get the shots they need during these visits.

When should a well-child checkup occur?

Your child should visit his or her PCP for these well-child checkups. They should go even when they are well, and go at these times, as recommended by the American Academy of Pediatrics:

- At birth, in the hospital
- 3-5 days
- 1 month old
- 2 months old
- 4 months old
- 6 months old
- 9 months old
- 12 months old
- 15 months old
- 18 months old
- 24 months old
- 30 months old
- Every year during ages 3-20 years old

How much does a well-child checkup cost me?

Nothing. Checkups are done by your child's PCP at no cost to you.

What if I need help getting a doctor visit?

We can help you get an appointment. Just call Customer Service toll-free at **1-888-846-4262**.
TTY users may call **711**. We're here for you from 7:45 a.m. to 4:30 p.m. HST.

What if I need help getting to the doctor visit?

We can help you get a ride to the doctor. Call Customer Service toll-free at **1-888-846-4262**.
TTY users may call **711**. We're here for you from 7:45 a.m. to 4:30 p.m. HST.

Pediatric Preventive Health Guidelines

On the next few pages of this book are guidelines for preventive care services. These tell you when you and your family should get checkups, tests and shots.

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

We help you remember to get these services. We send each family member a reminder every year on their birthday. It tells them about the tests and shots they may need.

These guidelines do not replace your PCP's advice. When you see your PCP, they may tell you that other needed services. This is based on your healthcare needs. Always talk with your PCP. Be sure to tell them about your health concerns. This will help you and your family get the right care.

Remember – if you just joined the plan, you should see your PCP within 90 days.

The following chart includes recommendations published by the American Academy of Pediatrics and Bright Futures; Centers for Disease Control and Prevention; and the U.S. Preventive Services Task Force (USPSTF).[1,2,3,4]

Pediatric Preventive Health Guidelines – Newborn to 21 Years Old

Age	Well-Child Checkups and Shot Guide
Newborn	• Well-baby checkup* at birth • Hearing screening • Newborn screening blood tests • Dose 1 of 3 of the Hepatitis B (HepB) vaccine

Age	Well-Child Checkups and Shot Guide
3–5 days	• This visit is especially important if your baby was sent home within 48 hours of birth • Well-baby checkup as recommended by your doctor • Newborn screening blood tests • Dose 1 of 3 of the Hepatitis B (HepB) vaccine, if not done at birth
1 month	• Well-baby checkup • Newborn screening blood tests if not already completed • Dose 2 of 3 of the Hepatitis B (HepB) vaccine • TB screening
2 months	• Well-baby checkup • Newborn screening blood tests if not already completed • Dose 2 of 3 of the Hepatitis B (HepB) vaccine, if not already received • Rotavirus (RV); Diphtheria, Tetanus, and Pertussis (DTaP); Haemophilus influenza type b (Hib); Pneumococcal conjugate (PCV); and inactivated poliovirus (IPV) vaccines
4 months	• Well-baby checkup • Hemoglobin (Hgb) screening; • Rotavirus (RV); Diphtheria, Tetanus, and Pertussis (DTaP); Haemophilus influenzae type b (Hib); Pneumococcal conjugate (PCV); and inactivated poliovirus (IPV) vaccines
6 months	• Well-baby checkup • Dose 3 of the Hepatitis B (HepB) vaccine (recommended between ages 6 to 18 months) • Rotavirus (RV); Diphtheria, Tetanus, and Pertussis (DTaP); Pneumococcal conjugate (PCV); and inactivated poliovirus (IPV) vaccines • Begin yearly flu shot • TB screening, oral health screening and blood lead risk assessment

Age	Well-Child Checkups and Shot Guide
9 months	• Well-baby checkup • Dose 3 of the Hepatitis B (HepB) vaccine (if not already received; recommended between ages 6 to 18 months) • Dose 3 the inactivated poliovirus (IPV) vaccines (if not already received; recommended between ages 6 to 18 months) • Yearly flu shot if not already received • Screenings for developmental health and oral health as well as a blood lead risk assessment
12 months	• Well-baby checkup • Catch-up immunizations as needed • Dose 3 of the Hepatitis B (HepB) vaccine (if not already received; recommended between ages 6 to 18 months) • Dose 3 of the inactivated poliovirus (IPV) vaccines (if not already received; recommended between ages 6 to 18 months) • Haemophilus influenza type b (Hib); Pneumococcal conjugate (PCV); Varicella (VAR); Measles, Mumps, Rubella (MMR); and the Hepatitis A (HepA) vaccines • Yearly flu shot if not already received • Screenings for TB, developmental health, anemia, and oral health as well as a blood lead risk assessment • Dental visit as need-identified by child's doctor**

Age	Well-Child Checkups and Shot Guide
15 months	• Well-baby checkup • Catch-up immunizations as needed • Dose 3 of the Hepatitis B (HepB) vaccine (if not already received; recommended between ages 6 to 18 months) • Dose 4 of the Diphtheria, Tetanus, and Pertussis (DTaP) vaccine (recommended between ages 15 to 18 months) • Haemophilus influenza type b (Hib) and Pneumococcal conjugate (PCV) vaccines • Dose 3 of the inactivated poliovirus (IPV) vaccines (if not already received; recommended between ages 6 to 18 months) • Dose 2 of Hepatitis A (HepA) vaccines (recommended between ages 12 to 23 months) • Yearly flu shot if not already received • Screenings for developmental health and oral health as well as a anemia risk assessment • Dental visit as need-identified by child's doctor**
18 months	• Well-baby checkup • Catch-up immunizations as needed • Dose 3 of the Hepatitis B (HepB) vaccine (if not already received; recommended between ages 6 to 18 months) • Dose 4 of the Diphtheria, Tetanus, and Pertussis (DTaP) vaccine (if not already received; recommended between ages 15 to 18 months) • Dose 3 of the inactivated poliovirus (IPV) vaccines (if not already received; recommended between ages 6 to 18 months) • Dose 2 of Hepatitis A (HepA) vaccines (to be taken 6 months after dose 1; recommended between ages 12 to 23 months) • Yearly flu shot if not already received • Screenings for developmental health, autism, anemia, and oral health as well as a blood lead risk assessment • Dental visit as need-identified by child's doctor**

Age	Well-Child Checkups and Shot Guide
24 months	• Well-child checkup • Catch-up immunizations as needed • Yearly flu shot if not already received • Screenings for TB, developmental health, autism, oral health, anemia, and cholesterol (dyslipidemia), as well as a blood lead risk assessment • Dental visit as need-identified by child's doctor**
30 months	• Well-child checkup • Catch-up immunizations as needed • Yearly flu shot if not already received • Screenings for developmental health, oral health, and anemia • Dental visit as need-identified by child's doctor**
3 years	• Well-child checkup • Catch-up immunizations as needed • Yearly flu shot if not already received • Screenings for TB, developmental health, oral health and anemia • Blood lead risk assessment (if not completed between ages 12 and 24 months) • Dental visit as need-identified by child's doctor**; may be up to twice a year
4–5 Years	• Well-child checkup • Catch-up immunizations as needed • Dose 5 of the DTaP vaccine • Dose 4 of the IPV vaccine • Dose 2 of the MMR vaccine • Dose 2 of the VAR vaccine • Yearly flu shot if not already received • Screenings for TB, developmental health, autism, oral health, hearing, vision (between age 4 and 5 years), anemia, and cholesterol (dyslipidemia) (if not done at 24 months) • Blood lead risk assessment (if not completed between ages 12 and 24 months) • Dental visit as need identified by child's doctor**; may be up to twice a year

Age	Well-Child Checkups and Shot Guide
6–20 years (even years)	• Well-child checkup every year • Catch-up immunizations as needed • Yearly flu shot if not already received • Dental visit twice a year • Screenings for TB and developmental health • Hearing tests at ages 6, 8, 10, and every year until the age of 21 • Vision screening at ages 6, 8, 10 and 12; follow-up screenings should be done at ages 15 • Cholesterol (dyslipidemia) screening at ages 6, 8, and then annually • Blood sugar screening beginning at age 10 and continuing every three years when at risk (see below) • Blood lead risk assessment at age 6 • Anemia risk assessment every year • Depression screening every year starting at age 11 • Tobacco, alcohol, or drug use risk assessment every year starting at age 11 • STI screening to be performed for sexually active individuals, as appropriate every year starting at age 11
11–12 years	• Well-child checkup every year • Catch-up immunizations as needed • Human papillomavirus vaccine (HPV) at a minimum age of 9 • Dose 1 of meningococcal conjugate vaccine (MCV) • Tetanus, diphtheria and pertussis (Tdap) • Yearly flu shot if not already received • Dental visit twice a year
13–17 years	• Well-child checkup every year • Catch-up immunizations as needed • MCV4 booster (at age 16 years). Tdap if not done previously • Human papillomavirus vaccine (HPV) at a minimum age of 9 • Yearly flu shot if not already received • Dental visit twice a year

Age	Well-Child Checkups and Shot Guide
18–20 years (up to 21st birthday)	• Well-child checkup every year • Catch-up immunizations as needed • Yearly flu shot if not already received • Dental visit twice a year • Cervical cancer screening starting at age 21***

Notes:

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

**Dental visits may be recommended starting at age 6 months.

***The U.S. Preventive Services Task Force (USPSTF) recommends against screening for cervical cancer in women younger than age 21, unless a patient has immune suppression or infection with HIV, in which case annual Pap tests are started with the onset of sexual activity.

Children With Asthma

If your child has not seen his or her doctor in the past three months, call to make an appointment. Your child's PCP can work with you to help keep your child's asthma under control and on track with his or her asthma action plan.

Children With Diabetes

Testing for diabetes mellitus (DM) should start at age 10 (or at onset of puberty) and should continue every two years if the following criteria are met:

- Overweight (BMI >85th percentile for age and sex; weight for height >85th percentile; or weight >120% of ideal for height) AND two of the following risk factors:
- Family history of type 2 diabetes in first- or second-degree relative
- Race/ethnicity (Native American, African American, Hispanic, Asian American, Pacific Islander)
- Signs of insulin resistance or conditions associated with insulin resistance (acanthosis nigricans, hypertension, dyslipidemia, polycystic ovarian syndrome, or small for gestational age birth weight)
- Maternal history of diabetes or gestational diabetes mellitus (GDM) during the child's gestation

References

[1] *American Academy of Pediatrics and Bright Futures. Recommendations for preventive pediatric health care.*

[2] *Centers for Disease Control and Prevention, published annually. Recommended immunization schedule for persons aged 0 through 6 years – United States.*

[3] *Centers for Disease Control and Prevention, published annually. Recommended immunization schedule for persons aged 7 through 18 years – United States.*

[4] *Centers for Disease Control and Prevention, published annually. Catch-up immunization schedule for persons aged 4 months through 18 years who start late or who are more than 1 month behind – United States.*

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Adult Preventive Health Guidelines

Frequency of Physical Examination

The best practice recommendations detailed below represent services considered medically necessary by WellCare to prevent certain diseases and medical conditions in adults. WellCare strongly recommends that all members receive the necessary preventive services, leading to improved healthcare quality and outcomes. All new members should get a baseline physical exam in the first 90 days of enrollment. *Pregnant members should be seen in the first 14 days of enrollment*.

The following chart includes recommendations published by the U.S. Preventive Services Task Force (USPSTF); Centers for Disease Control and Prevention; American Academy of Family Physicians; American Cancer Society; American Academy of Pediatrics; American Congress of Obstetricians and Gynecologists; American Society of Clinical Oncology; National Comprehensive Cancer Network (NCCN); American Diabetes Association; and the American Optometric Association.[1-13]

Recommendations for periodic health exam visits for asymptomatic adults include:

- **Ages 18 to 39 years:** Exam frequency: every 1 to 3 years
- **Ages 40 to 64 years:** Exam frequency: every 1 to 2 years based on risk factors
- **Ages 65 and over:** Exam frequency: every year

Age	Screening	Frequency
Adolescents 18 and older Adults 21 and older	Blood Pressure, Height, Body Mass Index (BMI), Alcohol Use	Annually, 18–21 years; after 21, every 1–2 years or per PCP recommendations
Adults 21 years and older, especially if at high risk	Cholesterol	Every 5 years (More frequent if elevated)
Women 21 years and older	Pap test	Every 3 years or per PCP's recommendations
Women 40 years and older	Mammography	Every 1–2 years
50 years and older	Colorectal	Periodically, depending upon test
50 years and older	Hearing Screening	Periodically
Women > 65 years old, or > 60 years at risk	Osteoporosis (Bone Mass Measurement)	Every 2 years or per PCP recommendations
65 years and older, or younger for those that have diabetes or other risk factors	Vision (including glaucoma or diabetic retinal exam, as needed)	Every 2 years for routine exams, or annually if diabetic or other risk factors

Immunizations	
Haemophilus Influenza type B (Hib)	For eligible members who are at high risk and who have not previously received Hib vaccine
Hepatitis A Vaccine (HepA)	All unvaccinated individuals who anticipate close contact with an international adoptee or those with certain high-risk behaviors
Hepatitis B Vaccine (HepB)	Adults at risk, 18 years of age and older
Human Papillomavirus (HPV)**	*For eligible members through 26 years of age (three-dose series)
Measles, Mumps, Rubella (MMR)	Adults born during or after 1957 should receive 1–2 doses
Meningococcal A,C,W,Y (MenACWY)	College freshmen living in dormitories not previously vaccinated and others at risk, 18 years of age and older.
Pneumococcal Polysaccharide (PPSV)	65 years of age and older, all adults who smoke or have certain chronic medical conditions – 1 dose, may need a 2nd dose if identified at risk
Seasonal Influenza	All adults annually
Tetanus-Diphtheria and Acellular Pertussis (Td/Tdap)	18 years and older, Tdap: Substitute 1-time dose of Tdap for Td then boost with Td every 10 years
Varicella (VAR)	All adults without evidence of immunity to varicella should receive 2 doses of single-antigen varicella vaccine if not previously vaccinated or the second dose if they have received only 1 dose
Zoster	Age 50 years or older – 2 doses

Prevention

- Discuss aspirin to prevent cardiovascular events
  - Men – 40 years and older periodically
  - Women – 50 years and older periodically
- Discuss the importance of preventive exams (mammograms and breast self-exam for women at high risk and who have family history).
- Discuss prostate-specific antigen (PSA) test and rectal exam for men after 40 years old per PCP discretion

Counseling

- Calcium Intake: 1,000 mg/day (women ages 18–50 years old), 1200 mg/day (women > 50 years)
- Folic Acid: 0.4 mg/day (women of childbearing age); women who have had children with Neural Tube Defects (NTD) should take 4 mg/day
- Miscellaneous Topics: tobacco cessation, drug/alcohol use, STDs/HIV, nutrition, breastfeeding (for pregnant women) physical activity, sun exposure, oral health, injury prevention, medication lists and poly-pharmacy, and advance directives

References

[1] *U.S. Preventive Services Task Force (USPSTF). Recommendations on variety of topics.*

[2] *Centers for Disease Control and Prevention. Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention.*

[3] *American Academy of Family Physician. Clinical recommendations.*

[4] *American Cancer Society Guidelines for the Early Detection of Cancer.*

[5] *American Academy of Pediatrics. Policy statement: breastfeeding and the use of human milk.*

[6] *American Congress of Obstetricians and Gynecologists. Optimizing Support for Breastfeeding as Part of Obstetric Practice (Committee Opinion 658).*

[7] *American College of Obstetricians and Gynecologists. Practice bulletin no. 129: osteoporosis.*

[8] *Centers for Disease Control and Prevention. Recommended adult immunization schedule for ages 19 years or older - United States, published annually.*

[9] *American Congress of Obstetricians and Gynecologists. ACOG statement on breast cancer screening guidelines.*

[10] *American Society of Clinical Oncology. Clinical practice guidelines.*

[11] *National Comprehensive Cancer Network (NCCN). NCCN Guidelines.*

[12] *American Diabetes Association. Standards of medical care in diabetes, published annually.*

[13] *American Optometric Association. Recommended eye examination frequency for pediatric patients and adults.*

Always talk with your doctor(s) about the care that is right for you. This material does not replace your doctor's advice. It is based on third-party sources. We are presenting it for your information only. It does not imply that these are benefits covered by ʻOhana. Also, ʻOhana does not guarantee any health results. You should review your plan or call Customer Service to find out if a service is covered.

Call **911** or your doctor right away in a health emergency.

Advance Directives

Your Care is Your Decision

The Hawaiʻi Uniform Health Care Decisions Act says you have a right to refuse medical treatment. This law also lets you tell your doctor what kinds of treatment you do or don't want in the future. This includes life-prolonging care. As your health plan, we have a responsibility to tell you about advance directives. If there is a change to an advance directives law, we will let you know no later than 90 days after the change is made.

Advance Directives Help You Make Your Wishes Known

An advance directive is a legal document. It tells providers what type of care you want to get (or not get) if you cannot tell them yourself. Having an advance directive will not affect the type of care you receive.

There are two types. One is an individual instruction (sometimes known as a living will). The other is a durable power of attorney for healthcare decisions.

An individual instruction tells what type of care you want if you cannot make decisions yourself. It is used when you cannot make your wishes known to your doctor.

A durable power of attorney for healthcare decisions names the person you want to make choices for you. It will be used if you cannot make choices for yourself. It also will be used if you cannot tell your provider about the care you want.

ʻOhana does not place limits on your advance directives. ʻOhana does not discriminate against its members by requiring or not requiring advance directives as a condition of care.

Where can I get an advance directives form?

You can call a lawyer or your local legal aid office. You can also ask your provider or call Customer Service. Call toll-free **1-888-846-4262**. TTY users may call **711**.

How can I learn more about advance directives?

Customer Service can help you learn more. Call toll-free at **1-888-846-4262**. TTY users may call **711**. A representative will help you sign up for a free educational session. You can also ask your provider for more information.

Can I change my advance directive?

Yes, you can change your advance directive whenever you want. You may want to contact a lawyer for help. It is a good idea to look over your advance directives from time to time. Make sure they still say what you want and that they cover all areas.

What should I do with my forms after filling them out?

You should give copies to your doctor and healthcare facility to put into your medical record. Give one to a trusted family member or friend. Keep a copy with your personal papers. You should send a copy to ʻOhana. We will make sure this is a permanent part of your healthcare record. You may want to give one to your lawyer or clergy person. Be sure to tell your family, friends, or persons close to you about what you have done. Don't just put these forms away and forget about them.

Do my caregivers have to follow my advance directives?

Yes, as long as your advance directives follow state law. A caregiver may not follow your wishes if they go against his or her conscience. (This means it is possible that a specific treatment or medication you list in your advance directive may be denied to you because the provider cannot in good conscience authorize it.) If so, they will help you find someone else who will follow your wishes. In addition, healthcare facilities are not required to implement an advance directive if there is an institution-wide conscientious objection and state law allows such an objection.

What happens if my wishes aren't followed?

Other than for conscience reasons, your wishes should be followed. You can file any reports of non-compliance with the Office of Health Care Assurance:

Department of Health, Office of Health Care Assurance
Medicare Section
601 Kamokila Blvd., Suite 395
Kapolei, HI 96707

Phone: **1-808-692-7420**
Fax: **1-808-692-7447**

Member Grievance and Appeal Procedures

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

This section explains how you can express your concerns.

There are two types of concerns. They are called grievances and appeals. Federal law lets you make a grievance if you have any problems with the plan. The state has helped set the rules for filing a grievance and what we must do when we get one. If you file a grievance or an appeal, we must be fair. We cannot disenroll you or treat you differently because you filed a grievance or appeal.

Grievances

What is a grievance?

A grievance is when you call or write to express your dissatisfaction with a provider, the plan or a service. It may be about:

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

How do I file a grievance?

You can file a grievance at any time. You or another person on your behalf can file a grievance by calling or writing to us. Your doctor or another provider can also file a grievance for you if you authorize them to do so. To authorize your provider to file your grievance, you must send your authorization in writing.

The time frame for standard grievances may be extended up to 14 calendar days if:

- The member asks for an extension or the plan shows that more information is needed and the delay is in the member's interest.
- The time frame is extended for a reason other than at the member's request.

The plan must verbally/orally explain the delay to the member:

- By close of business of the day the decision to extend is made; and
- Within two calendar days of the decision of the reason for the delay. This must be in writing.

Resolve the grievance as quickly as the member's health requires. It cannot be later than the date the extension expires.

When can I file a grievance?

You can file a grievance at any time. Call toll-free at **1-888-846-4262**. TTY users may call **711**. Or write to:

'Ohana Health Plan
Attn: Grievance Department
949 Kamokila Blvd.
3rd Floor, Suite 350
Kapolei, HI 96707

We can help you if you speak another language. You can also call Customer Service if you need help to file your grievance. Within five business days of getting your grievance, we will mail you a letter telling you we received it. We will make a decision within 30 calendar days of receiving the grievance.

State Grievance Review

You can also ask for State Grievance Review. This must be done within 30 calendar days of when you receive your grievance response letter from us. To ask for this review, call or write to the MQD at:

Med-QUEST Division
Healthcare Services Branch
P.O. Box 700190
Kapolei, HI 96709-0190

O'ahu: **1-808-692-8094** (TTY **1-808-692-7182**)

Neighbor Islands: **1-800-316-8005** (toll-free) (TTY **1-800-603-1201**)

Someone will review the grievance and respond within 90 calendar days of getting it.

Appeals

What is an appeal?

An appeal is a request you can make when you do not agree with our decision about the healthcare you are getting and/or our timeliness. You can request an appeal when any of the following actions occur:

- If we deny or limit a service you or your doctor asks us to approve
- If we reduce or stop services you have been getting that we already approved
- If we do not pay for the healthcare services you get

- If we fail to give services in the required time frame
- If we fail to give you a decision on an appeal you already filed in the required time frame
- If we fail to give you a resolution on a grievance in the required time frame
- If we do not agree to let you see a doctor that is not in our network and you live in a rural area or in an area with limited doctors
- If you want to dispute a financial liability

You will get a letter from us when any of these actions occur. This letter is called a Notice of Adverse Benefit Determination. You can file an appeal if you do not agree with our decision.

How do I file an appeal?

You must file your appeal within 60 calendar days from the date you receive your Notice of Adverse Benefit Determination letter. You can file by calling or writing to us. If needed, we can help you file your appeal. You can also get help from others. Your provider or someone else you choose to act for you can help. They can file for you if you give them your written permission.

There is only one level of appeal with the Plan.

Call Customer Service toll-free at **1-888-846-4262**. TTY users may call **711**. Or write to us at:

Send Your Written Appeals Here	
For appeal requests for medical services: **ʻOhana Health Plan** **Attn: Appeals Department** **P.O. Box 31368** **Tampa, FL 33631-3368**	**For appeal requests for pharmacy medications:** **ʻOhana Health Plan** **Attn: Pharmacy Medication Appeals Department** **P.O. Box 31398** **Tampa, FL 33631-3398**
Fax to: 1-866-201-0657	**Fax to: 1-888-865-6531**

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

What if I need an expedited (fast) appeal?

You or your doctor can ask for a fast appeal. We will give you a fast appeal if your doctor says waiting could seriously harm your health. You may ask for a fast appeal without a doctor's help. We will decide if you need a fast decision. You or your provider must call or fax us to ask for a fast appeal. Call toll-free **1-888-846-4262**. TTY users may call **711**. We're here for you Monday through Friday, 7:45 a.m. to 4:30 p.m. HST.

If your request was filed verbally, written notice is not needed. For fast appeals, we will call you. We will send a letter with the appeal decision within 72 hours.

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

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

What if I would like to submit additional information?

You or someone appealing for you may give us more information. You may do this throughout the appeal review process. Your time to submit more information for an expedited appeal is limited due to the short processing time frame. You also may review your appeal file any time during and/or after the review of your appeal.

You can also ask us for up to 14 more calendar days for you to provide more information. We may also ask for 14 more calendar days if we feel more information is needed and it is in your best interest. If we ask for the extra days, we will send you a written notice. The notice will also tell you when the review will be completed.

What if I do not like an appeal decision?

You may not like the appeal decision we make. If so, you can ask for State Administrative Hearing. Someone you choose to act for you can also ask for one. You must do this within 120 calendar days from receipt of the appeal decision letter from the internal appeal. The letter will tell you how to file for State Administrative Hearing with the Administrative Appeals office. You can only ask for State Administrative Hearing after you have gone through our complete appeals process. To do so, send your request to the address below.

State of Hawai'i Department of Human Services
Administrative Appeals Office
P.O. Box 339
Honolulu, HI 96809-0339

At the State Administrative Hearing, you may represent yourself. You may also use legal counsel, a relative, a friend or other spokesperson to represent you.

The State will make a decision within 90 calendar days from the date the request was filed.

What happens with my medical benefits (services) during the appeal or State Administrative Hearing process?

We will continue your services if ALL of the following happen:

- An appeal was requested within 60 calendar days from the date you receive your Notice of Adverse Benefit Determination letter

- Your appeal or request for a State Administrative Hearing involves an action we are taking to stop, or reduce services we had already approved.
- The services were ordered by an authorized provider.
- The original time frame covered by the approval we gave has not ended yet.
- You request that we continue your services in a timely manner, defined as on or before the later of the following:
  - Within 10 calendar days of the date we mailed you the Notice of Adverse Benefit Determination letter; or
  - The date we planned to stop or reduce your service(s)

We will continue your benefits until:

- You withdraw your request for the appeal or State Administrative Hearing;
- You do not ask for an appeal or State Administrative Hearing and continuation of benefits within 10 calendar days from when the plan mails a Notice of Adverse Benefit Determination; or
- A State Administrative Hearing decision is unfavorable to you.

If our decision on your appeal, or the State's decision (if you requested a State Administrative Hearing), is to deny the services, we may ask you to pay for the services you received while waiting for the decision.

Important Member Information

Enrollment Information

Enrollment

If you did not choose a health plan, the MQD chose ʻOhana for you through an auto-assignment.

Remember to Recertify Your Eligibility With the Hawaiʻi Department of Human Services (DHS)/Med-QUEST Division (MQD)

You will receive paperwork from DHS. It is sent when it's time to recertify your eligibility. This paperwork will tell you what you need to do and by what date. Be sure to provide all of the information that's required.

Remember to recertify your eligibility with DHS/MQD. If you don't, you may lose your benefits. ʻOhana will call you to remind you to recertify your eligibility.

Here are some of the items you may need:

- Your original birth certificate (or a certified copy)
- A picture ID (like a driver's license)
- Your Social Security number
- Information like your paycheck stub, child support, bank account details and other insurance you may have (through your job)

It's important that you tell us and DHS when you move. That way your recertification paperwork is sent to the right address.

Make sure you complete this paperwork. And do it quickly. If you don't, your benefits could end. If you have questions about recertifying your Medicaid eligibility, call us.

Or you can call DHS/MQD toll-free at **1-800-316-8005** (TTY **1-800-603-1201**).

Reinstatement

If you lose your Medicaid eligibility and get it back within six months, the State will put you back in our plan. We'll send you a letter within 10 days after you become a member again. You can choose the same PCP you had or pick a new one.

Plan Structure, Operations and Provider Incentive Programs

The people of ʻOhana Health Plan are dedicated to helping you get the most out of your health plan. Our Health Coordinators and Customer Service representatives can help you get the care you need. Anytime you need help, call us toll-free at **1-888-846-4262**. TTY users may call **711**. And you can always stop by one of our offices on Oʻahu, Maui or the Big Island.

ʻOhana works with your doctors to make sure you get the right care at the right time. This includes preventive care. We sometimes offer your doctors incentives, or bonuses. We do this to encourage them to keep you on track with your wellness visits throughout the year. (Please make sure to read the *Preventive Health Guidelines* section in this handbook for all of the wellness visits you should plan for with your doctor each year.) If you have any questions about this, Customer Service can help answer them.

How Our Providers are Paid

'Ohana works hard to give you the care you need. We work with many providers.

You may ask how they are paid and if how they are paid affects how they use referrals. You may also ask if it will affect other services you may need. Call Customer Service for more information.

Evaluation of New Technology

We look at new technology every year. We also look at the ways we use the technology we have. The findings are reviewed to:

- Determine how new advancements can be included in the benefits that members receive
- Make sure that members have fair access to safe and effective care
- Make sure we are aware of changes in the industry

The review of new technology is done in these areas:

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

To learn more, call Customer Service.

Quality and Member Satisfaction Information

You can ask about how the plan has performed. You can also ask if our members are satisfied and/or provide ideas for how we can improve. We give you highlights of areas that we are working on each year in the member newsletter. To get more information or a copy of the newsletter, call Customer Service.

Fraud, Waste and Abuse

Billions of dollars are lost to healthcare fraud every year. What are healthcare fraud, waste and abuse? It's when false information is given on purpose. This can be done by a member or provider. This false information can lead to someone getting a service or benefit that is not allowed. It can also lead to a provider receiving payment for services that were not performed.

Here are some other examples of fraud, 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
- Overbilling the plan
- Using someone else's 'Ohana ID card to get services
- Waiving patient co-pays or deductibles
- Obtaining medications and then selling the medications to someone else
- Requesting and receiving transportation services to go somewhere other than to a medical appointment

If you think or know that fraud, waste or abuse has occurred, tell us. We will determine if something is fraud, waste or abuse. Call our 24-hour Fraud Hotline. The toll-free number is **1-866-685-8664**. It is private and you may leave a message without leaving your name. If you do leave your phone number, we will call you back. We do this to be sure our information is complete and accurate. You can also report fraud on our website. Submitting a report online is private. Go to **www.ohanahealthplan.com**.

You can also send a report in writing to:

'Ohana Health Plan
Attn: Special Investigations Unit
P.O. Box 31407
Tampa, FL 33631-3407

Member Rights and Responsibilities

As an 'Ohana member, you have the right:

- To get information about the plan, its services, its practitioners, and its providers.
- Receive information as required by 42CFR438.100
- To get information and make recommendations about your rights and responsibilities policy.
- To have the protections listed in the Patients' Bill of Rights and Responsibilities Act (HRS Chapter 432E).
- To know the names and titles of the providers who take care of you.
- To be treated with respect.
- To be treated with dignity.
- To privacy.
- To decide with your provider on the care you get.
- To freely talk about the care you need for your particular health conditions. This includes the choices and risks involved, regardless of the cost or benefit coverage. You must get this information in a way you understand.
- To know about your healthcare needs after you get out of the hospital or leave a provider's office.
- To refuse care, as long as you agree to be responsible for your decision.
- To not take part in any medical research.

- To complain or appeal about the plan or the care it provides and to know that if you do, it will not affect how you are treated.
- To be free from any form of restraint or seclusion as a means of force, discipline, convenience or retaliation.
- To request and get a copy of your medical records (45CFR parts 160 and 164 subparts A and E).
- To request to amend or correct your medical records (45CFR 164.524 and 154.526)
- To have your records kept private.
- Receive care that meets the requirements for timely access and medically necessary coordinated care (42CFR438.206 through 42CRF438.210)
- To make your healthcare wishes known by using advance directives.
- To have input in the plan's member rights and responsibilities.
- To use these rights no matter your sex, age, race, ethnicity, income, education or religion.
- To have all plan employees honor your rights.
- To get healthcare services that are accessible and comparable in amount, duration and scope to those provided under Medicaid Fee-for-Service (FFS) and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- To get all information in a way that you can easily understand, in alternative formats and in a manner that takes into consideration your special needs.
- To get help in understanding the rules and benefits of the plan.
- To get verbal interpretation services, at no cost. This is for all non-English languages, not just those that are most common.
- To be told that verbal interpretation is available to you – and how to get this service.
- To get information about:
  - The basic features of managed care
  - Who may or may not join the program
  - The plan's responsibilities for coordination of care in a timely manner in order to make an informed choice (potential members)
- To get a complete description of your right to leave the plan at least once a year.
- To get a notice of any major change in benefits. You must get this at least 30 days before the change is to go into effect.
- To get full information about emergency and after-hours services.
- To get the plan's policy on referrals for specialty care and other benefits that are not provided by your PCP.
- To have all these rights apply to the person who you legally appoint to make decisions about your healthcare.
- To freely exercise your rights, including those related to filing a grievance or appeal, and that the exercise of these rights will not adversely affect the way you are treated.

- To have direct access to a women's health specialist within the network.
- To receive a second opinion at no cost to you.
- To receive services out-of-network if the health plan is unable to provide them in-network for as long as the health plan is unable to provide them in-network and not pay more than you would have if services were provided in-network.
- To receive services according to the appointment waiting time standards.
- To receive services in a culturally competent manner.
- To receive services in a coordinated manner.
- To have your privacy protected.
- To be included in service and care plan development.
- To have direct access to specialists (if you have a special healthcare need).
- To not have services arbitrarily denied or reduced in amount, duration or scope solely because of diagnosis, type of illness or condition.
- To receive a description of cost sharing responsibilities, if any.
- To not be held liable for:
  - The health plan's debts in the event of insolvency
  - The covered services provided to you by the health plan for which the DHS does not pay the health plan
  - Covered services provided to you for which the DHS or the health plan does not pay the healthcare provider that furnishes the services; and payments of covered services furnished under a contract, referral or other arrangement to the extent that those payments are in excess of the amount you would owe if the health plan provided the services directly
  - Only be responsible for cost-sharing as described by your plan in accordance with 42 CFR Section 447.50 through 447.57.

Note

If 'Ohana Health Plan objects to providing a service on moral or religious grounds, the health plan must furnish information about the services it does not cover:

1. To the DHS within 120 days prior to adopting the policy with respect to any service
2. To members before and during enrollment
3. To members at least 30 days prior to the effective date of the policy with respect to any service

You also have responsibilities as a member:

- To give information that the plan and its providers need to give care.
- To follow plans and instructions for care that you have agreed on with your PCP.
- To understand your health problems.
- To help set treatment goals that you and your PCP agree to.

- To read the member handbook to understand how the plan works.
- To always carry your member ID card.
- To always carry your Medicaid card.
- To show your ID cards to each provider.
- To notify ‘Ohana if you lose your member ID card.
- To schedule appointments for all non-emergency care through your PCP.
- To get a referral from your PCP for specialty care.
- To cooperate with the people providing your healthcare.
- To be on time for appointments.
- To notify the provider’s office if you need to cancel or change an appointment.
- To respect the rights of all providers.
- To respect the property of all providers.
- To respect the rights of other patients.
- To not be disruptive in any provider’s office.
- To know the medicines you take, what they are for, and how to take them the right way.
- To make sure your PCP has copies of all of your previous medical records.
- To let the plan know within 48 hours, or as soon as possible, if you are admitted to the hospital or get emergency room care.
- To call ‘Ohana to get information or get your questions answered. Call Customer Service toll-free at **1-888-846-4262**. TTY users may call **711**.

1-888-846-4262 (TTY 711)

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