



Caring for you and  
your family

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# Member Handbook

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## **'OHANA ... YOUR HEALTH PLAN**

'Ohana is a managed care plan for Medicaid members who are aged, blind or disabled. 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 health care. We work with doctors, specialists, hospitals, labs and other health care facilities that are a part of our provider network to provide the benefits offered by Medicaid and to coordinate your health care needs. As a member, you may select a primary care provider (PCP). Your PCP will be your personal doctor. He or she will treat you for most of your health care needs and will work with you to direct your health care (for more information on PCPs, see pages 8–9).

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

This handbook will tell you more about your benefits and how your health plan works. Please read it and keep it in a safe place. We hope it will answer most of your questions. For additional help, please call Customer Service at 1-888-846-4262 (TTY/TDD: 1-877-247-6272). We have friendly staff trained to answer all of your questions. You can also visit the Web at [www.ohanahealthplan.com](http://www.ohanahealthplan.com).

We wish you good health!

This document contains important information. To request this information in an alternate language or to have it orally translated, please contact Customer Service at 1-888-846-4262 (TTY/TDD: 1-877-247-6272).

在這文件中包含重要資訊。若想獲取該資訊的其他語言版本或對其進行口頭翻譯，請聯繫我們的客戶服務部1-888-846-4262 (聽障電話：1-877-247-6272)。

이 문서에는 중요한 정보가 포함되어 있습니다. 정보를 구두로 번역하거나 대안 가능한 언어에 대한 정보 요청은 고객 서비스, 1-888-846-4262 (TTY/TDD: 1-877-247-6272)로 문의 하십시오.

Daytoy a dokumento ket naglaon iti napateg nga impormasyon. Tapno dawaten daytoy nga impormasyon iti sabali a lengguwahe wenno tapno maipatarus bayat pannakaibasana, makiuman koma iti Serbisyo iti Kliyente iti 1-888-846-4262 (TTY/TDD: 1-877-247-6272).

Ang dokumentong ito ay naglalaman ng mahalagang impormasyon. Upang hingin ito sa ibang lengguwahe o maisalin ito nang pasalita, mangyaring makipag-ugnayan sa Serbisyo sa Kostumer sa 1-888-846-4262 (TTY/TDD: 1-877-247-6272).

## **WE'RE HERE TO HELP**

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

### **HELP FROM 'OHANA CUSTOMER SERVICE**

You can call Customer Service Monday through Friday from 7:45 a.m. to 5:30 p.m. HST. Call with questions about:

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

Customer Service Toll-Free Phone Number:  
1-888-846-4262 (TTY/TDD: 1-877-247-6272)

You can also contact Customer Service by writing to:  
Customer Service  
Plaza at Mill Town  
94-450 Mokuola Street, Suite 106  
Waipahu, HI 96797

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

### **HELP FROM YOUR SERVICE COORDINATOR**

You will be assigned to a Service Coordinator. He or she will be your main connection to the plan. He or she will help arrange, monitor and make sure you get timely care. Your Service Coordinator will also make sure you get the right care. He or she can help you:

- Arrange services
- Get help with a provider
- Coordinate care with your doctor
- Find answers to your questions about things like your benefits, medical care or medicines

When your Service Coordinator does not have the answers, he or she will find someone who does.

He or she will get in touch with you to find out about your:

- Health history
- Existing services
- Cultural/linguistic needs

This helps us match you up with the Service Coordinator who best meets your needs. Then he or she will call you to set up a face-to-face visit to learn more about your health history. This visit will take place at least once each year so we can update any changes in your history. We will stay in touch with you about your services between visits and update your plan of care.

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

You can call your Service Coordinator anytime you need to during business hours and leave him or her a message. Regular business hours are Monday through Friday from 7:45am to 5:30pm HST. Call 1-888-846-4262 (TTY/TDD: 1-877-247-6272). Your Service 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 be able to 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 later in this handbook.

You will get contact information so you can reach your Service Coordinator. You will get details about your face-to-face visit as well. You can also write down this information here:

My Service Coordinator's Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## OTHER IMPORTANT PHONE NUMBERS

CONTACT NAME	TOLL-FREE PHONE NUMBER
24-Hour Nurse Advice Line	1-800-919-8807
TTY/TDD	1-877-247-6272
Service Coordination	1-888-846-4262 (TTY/TDD: 1-877-247-6272)
Transportation Requests (Logisticare)	1-866-790-8858
Transportation Ride Assist Line (Logisticare)	1-866-481-9699
Behavioral Health	1-888-846-4262 (TTY/TDD: 1-877-247-6272)
Dental	1-888-846-4262 (TTY/TDD: 1-877-247-6272)
Vision (Advantica)	1-888-846-4262 (TTY/TDD: 1-877-247-6272)
Hearing (HearUSA)	1-888-846-4262 (TTY/TDD: 1-877-247-6272)
Pharmacy	1-888-846-4262 (TTY/TDD: 1-877-247-6272)
Hawai'i MED-QUEST Division	1-800-586-5390

## VISIT OUR WEBSITE TO STAY INFORMED

Remember to visit our website often. You can get updated information on:

- Clinical practice guidelines
- Member rights and responsibilities
- How to get utilization management guidelines
- And much more

Plus, you can change your PCP and update your address and phone number on our website. Visit [www.ohanahealthplan.com](http://www.ohanahealthplan.com) today!

## THE 'OHANA DICTIONARY

### **Advance Directive**

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

### **Appeal**

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

### **Benefits**

Health care we cover.

### **Complaint (same as Grievance)**

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

### **Cost-Sharing**

How much you must pay when getting care from 'Ohana providers. Your state 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 'Ohana.

### **Durable Medical Equipment**

Medical items such as wheelchairs and oxygen tanks.

### **Emergency**

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

### **Environmental Accessibility Adaptations**

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

### **EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Comprehensive Visits**

Regular health exams for children. They are used to find and treat medical problems.

### **Generic Drug**

A drug that has the same basic ingredients as a brand-name drug.

### **Grievances**

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

### **Home Health Agency**

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

### **Health Maintenance Organization (HMO)**

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

### **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 Hawai'i.

**Inpatient**

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

**Long-Term Care**

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

**Managed Care Plan**

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

**Medically Necessary Services**

Medical services that are needed for you to get well and stay healthy.

**Med-QUEST Division (MQD)**

A division of the State Department of Human Services. It administers the Medicaid programs, including QExA.

**Member**

A person who has joined our plan.

**'Ohana 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 Drugs**

Drugs you can buy that are not behind the drug store counter and do not require a doctor's order.

**Pharmacy Network**

A group of drug stores that members can use.

**Post Stabilization**

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

**Preferred Drug List (PDL)**

Medicines approved by the Pharmacy and Therapeutics (P&T) Committee, which consists of 'Ohana doctors and pharmacists. These drugs are safe and cost less. The plan also has medicines it does not approve.

**Prescription Medicine**

A drug for which your doctor writes an order.

**Primary Care Provider (PCP)**

Your personal doctor or Advanced Practice Registered Nurse. He or she manages all your health care needs.

**Prior Authorization**

When we have to OK treatment or medicines ahead of time.

**Providers**

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

### **QUEST Expanded Access (QExA)**

A managed care program. It offers all acute and long-term care services to those eligible as aged, blind or disabled (ABD) under the Medicaid State Plan.

### **Referral**

When your PCP or Service Coordinator sends you to see another health care provider.

### **Specialist**

A doctor who works in a specific field of medicine.

### **Treatment**

The care you get from doctors and facilities.

### **WIC (Women, Infants and Children)**

A program that works with women, babies and children. It helps them with nutrition.

## **GETTING STARTED**

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

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

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

You will 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 'Ohana 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. 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 health care needs. Your PCP will work with you to direct your health care. He or she will do your checkups and shots and treat you for most of your health care needs. You can reach your PCP by calling his or her office. Your PCP's name and telephone number may be printed on your ID card.\*

Our PCPs are trained in different specialties. They include:

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

\* If you have Medicare, then you are not required to choose a PCP.

There are also times when you may receive a lot of your care from a certain specialist. They may be able to 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

### **3. Choosing your PCP**

‘Ohana members who do not have Medicare must choose a primary care provider (PCP). You may have done this already. If not, you will need to fill out the Member Data Change Form. This form came with your new member welcome letter. You have 15 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 on the Web at [www.ohanahealthplan.com](http://www.ohanahealthplan.com) to select a PCP.

If you do not have Medicare, a PCP will be assigned to you unless you pick one within 15 days of getting your new member welcome letter. The assignment will be based on the following:

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

### **4. Changing your PCP**

You can change your PCP. To do this, you can visit [www.ohanahealthplan.com](http://www.ohanahealthplan.com). Or you can complete the Member Data Change Form that came with your new member welcome letter. You can also call Customer Service.

You can change your PCP at any time. If the change is made between the first and 10th of the month, it will immediately become effective. Changes made after the 10th of the month will become effective the first 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, verify that the information is correct. Then destroy the old one.

For a list of our PCPs:

- Look in your provider directory
- Visit our website at [www.ohanahealthplan.com](http://www.ohanahealthplan.com)
- Call Customer Service

### **5. How to get services before choosing or being assigned a PCP**

You can get services after joining ‘Ohana and before you have a PCP. Just look in the provider directory that came with this packet. Then select a provider who is a part of our network. You can also see a list of providers on the Web at [www.ohanahealthplan.com](http://www.ohanahealthplan.com).

Call to set up an appointment and tell them you are an ‘Ohana member. Show them your welcome letter when you arrive for your visit. Your welcome letter will include your member ID number and will provide proof of your membership with ‘Ohana.

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

## **6. When your family's size changes**

Your family's make-up or size may change while you are an 'Ohana member. (For example, you may have a baby or get married.) If this happens, you need to call your eligibility worker and let them know.

## **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 **1-800-919-8807**. Call anytime someone in your family is sick or hurt or needs medical advice.

When you call, a nurse will ask you some questions about your problem. Tell him or her as much as you can—where it hurts, what it looks like and what it feels like. He or she can help you decide if you need to:

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

Call when you need help with problems like:

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

A nurse is there to help. So call the nurse advice line before you call a doctor or go to the hospital. In an emergency, go to the hospital or call **911** first.

## **8. In an emergency**

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

## **9. 'Ohana 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 54.

## **10. Call us for help**

Questions? Call us. We can get translators for all languages. We have materials available in Ilocano, Tagalog, Mandarin Chinese, Korean, large print, audio tapes and Braille. Sign language services are also available for hearing-impaired members. All of these services are available at no cost. Call **1-888-846-4262** (TTY/TDD: **1-877-247-6272**) weekdays from 7:45am to 5:30pm HST.

You can also contact Customer Service by writing to:

Customer Service  
Plaza at Mill Town  
94-450 Mokuola Street, Suite 106  
Waipahu, HI 96797

You are now ready to begin using all of the benefits you get with 'Ohana. We look forward to serving you.

## ACCESS TO COVERED SERVICES

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

Travel time to medical services:

Provider	Urban	Rural
PCPs, specialists, hospitals, emergency services facilities, mental health providers	30-minute driving time	60-minute driving time
Pharmacies	15-minute driving time	60-minute driving time
24-hour pharmacy	60-minute driving time	N/A

Timely care:

- Emergency care 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)
- Urgent care and PCP pediatric sick visits within 24 hours (urgent care is for a problem that is not life-threatening but could cause sickness or harm with no care)
- PCP adult sick care within 72 hours
- Specialist and non-emergency hospital stays within 4 weeks
- Routine and wellness visits within 21 days
- Follow-up care as needed
- Waiting times should be no more than 45 minutes for scheduled appointments

## 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 you are entitled to. These include primary, acute, behavioral health and long-term care services.

### COST-SHARING

Members may have to share in the cost of health care services. This happens when certain financial eligibility requirements are not met. A Hawai'i eligibility worker will find out your cost-sharing portion. He or she will tell you and us what it is. If you do have a cost-share amount, you will be responsible for paying your provider or us each month. Typically these would be paid to a long-term care facility or a home and community based provider.

### RECEIVING NON-COVERED SERVICES

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

Providers may not bill you 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.

## COVERED SERVICES

Services	Coverage and Limits
<b>Behavioral Health</b>	
<p><b>Inpatient and Outpatient Mental Health and Substance Abuse</b></p>	<p>Covered services include all medically necessary behavioral health services for QExA adult and child members excluding services covered by the Hawai'i Department of Health.</p> <p>Health Plan covered services include:</p> <ul style="list-style-type: none"> <li>• 24-hour-a-day care for acute psychiatric illnesses, including:               <ul style="list-style-type: none"> <li>- Room and board in an acute hospital</li> <li>- Nursing care</li> <li>- Medical supplies and equipment</li> <li>- Diagnostic services</li> <li>- Physician services</li> <li>- Other practitioner services, as needed</li> <li>- Other medically necessary services</li> </ul> </li> <li>• Ambulatory services, including 24-hours-a-day, 7-days-a-week crisis services</li> <li>• Acute day hospital/partial hospitalization, including:               <ul style="list-style-type: none"> <li>- Medication management</li> <li>- Prescribed drugs</li> <li>- Medical supplies</li> <li>- Diagnostic tests</li> <li>- Therapeutic services, including individual, family and group therapy and aftercare</li> <li>- Other medically necessary services</li> </ul> </li> <li>• Methadone treatment services, which include the provision of methadone or a suitable alternative (e.g., LAAM), as well as outpatient counseling services</li> <li>• Prescribed drugs including medication management and patient counseling</li> <li>• Diagnostic/laboratory services, including:               <ul style="list-style-type: none"> <li>- Psychological testing</li> <li>- Screening for drug and alcohol problems</li> <li>- Other medically necessary diagnostic services</li> </ul> </li> <li>• Psychiatric or psychological evaluation</li> <li>• Physician services</li> <li>• Rehabilitation services</li> <li>• Occupational therapy</li> <li>• Other medically necessary therapeutic services</li> </ul> <p><i>May require prior authorization. See details on page 32.</i></p>

Services	Coverage and Limits
<b>Physical Health</b>	
<b>Acute Inpatient Hospital Care</b>	<p>Includes the cost of room and board for inpatient stays for:</p> <ul style="list-style-type: none"> <li>• Nursing care</li> <li>• Medical supplies</li> <li>• Equipment</li> <li>• Drugs</li> <li>• Diagnostic services</li> <li>• Physical and occupational therapy</li> <li>• Audiology</li> <li>• Speech-language pathology services</li> </ul> <p><i>May require prior authorization. See details on page 32.</i></p>
<b>Outpatient Hospital Care</b>	<p>This service includes 24-hour-a-day, 7-days-per-week care for:</p> <ul style="list-style-type: none"> <li>• Emergency services</li> <li>• Ambulatory center services</li> <li>• Urgent care services</li> <li>• Medical supplies</li> <li>• Equipment and drugs</li> <li>• Diagnostic services</li> <li>• Therapeutic services (including chemotherapy and radiation therapy)</li> </ul> <p><i>May require prior authorization. See details on page 32.</i></p>
<b>Cognitive Rehabilitation Services</b>	<p>Services provided to cognitively impaired persons that assess and treat the following:</p> <ul style="list-style-type: none"> <li>• Communication skills</li> <li>• Cognitive and behavioral ability</li> <li>• Cognitive skills related to performing ADLS</li> </ul> <p>Covered services include assessments completed at regular times (determined by the provider and according to the member's needs).</p> <p><i>May require prior authorization. See details on page 32.</i></p>
<b>Cornea Transplants and Bone Graft Services</b>	<p>Cornea transplants (keratoplasty) and bone graft</p> <p><i>May require prior authorization. See details on page 32.</i></p> <p>Other transplants are covered under the State of Hawai'i Organ and Tissue Transplant Program, not the QExA program.</p>

Services	Coverage and Limits
<b>Physical Health</b>	
<b>Dental Services for Adults</b>	<p>Dental services are coordinated through Community Case Management Corporation (CCMC). CCMC will help members:</p> <ul style="list-style-type: none"> <li>• Find a dentist</li> <li>• Make an appointment</li> <li>• Coordinate transportation and translation services</li> </ul> <p>Call toll-free 1-866-486-8030.</p> <p>Health plan covered services include:</p> <ul style="list-style-type: none"> <li>• Providing dental services performed by a dentist or physician that are needed due to a medical emergency (e.g., car accident) where the services provided are primarily medical</li> <li>• Providing 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</li> </ul> <p><i>May require prior authorization. See details on page 32.</i></p> <p>The plan is not responsible for services that are provided in private dental offices, government-sponsored or subsidized dental clinics and hospital-based outpatient dental clinics.</p> <p>For adults, emergency dental services are also covered under the FFS dental plan.</p> <p>For children younger than 21 years old, preventive dental and treatment services are covered by the Med-QUEST fee-for-service (FFS) dental plan. They are coordinated through CCMC.</p>
<b>Durable Medical Equipment and Medical Supplies</b>	<p>Covered services and medical supplies include but are not limited to the following:</p> <ul style="list-style-type: none"> <li>• Oxygen tanks and concentrators</li> <li>• Ventilators</li> <li>• Wheelchairs</li> <li>• Crutches and canes</li> <li>• Eyeglasses</li> <li>• Orthotic devices</li> <li>• Prosthetic devices</li> <li>• Hearing aids</li> <li>• Medical supplies such as surgical dressings and ostomy supplies</li> <li>• Incontinency supplies</li> </ul> <p><i>May require prior authorization. See details on page 32.</i></p>

Services	Coverage and Limits
<b>Physical Health</b>	
<b>Emergency and Post-Stabilization Services</b>	<p>Covered for medically necessary services.</p> <p>Includes any screening examination services to find out whether an emergency medical condition exists.</p> <p>No prior authorization required.</p>
<b>Family Planning Services</b>	<p>Covers:</p> <ul style="list-style-type: none"> <li>• Education and counseling</li> <li>• Emergency contraception</li> <li>• Follow-up</li> <li>• Brief and comprehensive visits</li> <li>• Pregnancy testing</li> <li>• Contraceptive supplies and follow-up care</li> <li>• Diagnosis and treatment of sexually transmitted diseases</li> <li>• Infertility assessment</li> </ul> <p><i>May require prior authorization. See details on page 32.</i></p>
<b>Health Education and Counseling</b>	<ul style="list-style-type: none"> <li>• Substance use including alcohol</li> <li>• Diet and exercise</li> <li>• Injury prevention</li> <li>• Sexual behavior</li> <li>• Dental health</li> <li>• Family violence and depression</li> </ul> <p><i>May require prior authorization. See details on page 32.</i></p>
<b>Home Health Services</b>	<p>Some home health services included are:</p> <ul style="list-style-type: none"> <li>• Skilled nursing</li> <li>• Home health aides</li> <li>• Medical supplies</li> <li>• Physical and occupational therapy</li> <li>• Audiology and speech-language pathology</li> </ul> <p><i>May require prior authorization. See details on page 32.</i></p>

Services	Coverage and Limits
<b>Physical Health</b>	
<b>Hospice Services</b>	<p>Provides care to terminally ill patients who have a life expectancy of 6 months or less, as determined by their doctor.</p> <p>Medicaid services provided to members receiving Medicare hospice services that are duplicative of Medicare hospice benefits are not covered. Examples would include personal care and homemaker services. This is only covered when the service need is not related to the hospice diagnosis.</p> <p><i>May require prior authorization. See details on page 32.</i></p>
<b>Maternity Services</b>	<p>Covers:</p> <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Prenatal laboratory screening tests</li> <li>• Diagnostic tests</li> <li>• Treatment of missed, threatened and incomplete abortions</li> <li>• Delivery of infant</li> <li>• Postpartum care</li> <li>• Prenatal vitamins</li> </ul>
<b>Cesarean Delivery</b>	4-day stay after delivery
<b>Vaginal Delivery</b>	2-day stay after vaginal delivery
<b>Physician Services</b>	<p>Services must be medically necessary and provided at locations including but not limited to:</p> <ul style="list-style-type: none"> <li>• Physicians' offices</li> <li>• Clinics</li> <li>• Private homes</li> <li>• Licensed hospitals</li> <li>• Licensed skilled nursing facility</li> <li>• Intermediate care facility</li> <li>• Licensed or certified residential setting</li> </ul>
<b>Other Practitioner Services</b>	<p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> <li>• Certified nurse midwife services</li> <li>• Licensed advanced practice registered nurse services (including family, pediatric, geriatric, psychiatric health specialists)</li> <li>• Other medically necessary practitioner services provided by a licensed or certified health care provider</li> </ul>

Services	Coverage and Limits
<b>Physical Health</b>	
<b>Prescription Drugs</b>	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. Alternate drugs may be covered with a prior authorization.
<b>Preventive Services</b>	<p>Services include:</p> <ul style="list-style-type: none"> <li>• Initial and interval histories</li> <li>• Comprehensive physical examinations (including developmental services)</li> <li>• Immunizations</li> <li>• Family planning</li> <li>• Diagnostic and screening laboratory</li> <li>• X-ray services (including screening for tuberculosis)</li> </ul> <p><i>May require prior authorization. See details on page 32.</i></p>
<b>Personal Assistance Services — Level 1</b>	<p>May be covered when authorized by the Service Coordinator for members who need help with key daily activities to prevent a decline in health status and keep them in their home.</p> <p>Services may include:</p> <ul style="list-style-type: none"> <li>• Meal preparation</li> <li>• Laundry</li> <li>• Shopping</li> <li>• Errands</li> <li>• Light housekeeping tasks</li> </ul>
<b>Radiology/Laboratory/Other Diagnostic Services</b>	<p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Diagnostic</li> <li>• Therapeutic radiology and imaging</li> <li>• Screening and diagnostic laboratory tests</li> </ul> <p><i>May require prior authorization. See details on page 32.</i></p>
<b>Rehabilitation Services</b>	<p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Physical and occupational therapy</li> <li>• Audiology and speech-language pathology</li> </ul> <p><i>May require prior authorization. See details on page 32.</i></p>

Services	Coverage and Limits
<b>Physical Health</b>	
<b>Sterilizations</b>	<p>Covered for both men and women if you are:</p> <ul style="list-style-type: none"> <li>• At least 21 years of age at the time consent is obtained</li> <li>• Mentally competent</li> <li>• Voluntarily gives informed consent by completing the Informed Consent for Sterilization</li> <li>• Provider completes the Sterilization Required Consent Form</li> </ul> <p><i>May require prior authorization. See details on page 32.</i></p>
<b>Hysterectomies</b>	<p>Covered under the following requirements:</p> <ul style="list-style-type: none"> <li>• Members 21 and older</li> <li>• Voluntarily by the member (must complete the Hysterectomy Acknowledgement Form)</li> <li>• The member has been told orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing</li> <li>• The member has signed and dated a Patient's Acknowledgement of Prior Receipt of Hysterectomy Information Form before the hysterectomy</li> <li>• Procedure is medically necessary and is not solely for the purpose of rendering the individual permanently incapable of reproducing</li> </ul>
<b>Transportation Services</b>	<p>The plan provides both emergency and non-emergency ground and air services to and from medically necessary medical appointments for members who:</p> <ul style="list-style-type: none"> <li>• Have no means of transportation</li> <li>• Reside in areas not served by public transportation</li> <li>• Cannot access public transportation due to their medical condition</li> <li>• Do not live in a community care foster family home, adult residential care home, expanded adult residential care home, or domiciliary home</li> </ul> <p>Transportation is not provided to day programs that are not medically necessary. For more information about transportation, see page 29.</p> <p><i>May require prior authorization. Authorization is required for any ground transportation to a location greater than 35 miles from pick up location. See details on page 32.</i></p>
<b>Non-Medical Transportation</b>	<p>This service helps members travel as specified by the member care plan. It helps members get to community services, activities and resources.</p> <p>Whenever possible, those who can offer this service without cost will be used. They include family, neighbors, friends or community agencies.</p> <p><b>Exclusion:</b></p> <p><i>Members living in a residential care setting or a CCFH are not eligible for this service.</i></p>

Services	Coverage and Limits
<b>Physical Health</b>	
<b>Out-of-State and Off-Island Coverage</b>	<p>We provide any medically necessary covered services that are prearranged when not available on your island or in Hawai'i. This includes:</p> <ul style="list-style-type: none"> <li>• Referrals to an out-of-state or off-island specialist or facility</li> <li>• Transportation to and from the referral destination</li> <li>• Lodging &amp; meals</li> <li>• Member attendant (if authorized)</li> </ul> <p><i>May require prior authorization. See details on page 32.</i></p>
<b>Urgent Care Services</b>	<p>Covered as medically necessary. No prior authorization is required.</p>
<b>Vision Services</b>	<p>We provide eye and vision services for members:</p> <ul style="list-style-type: none"> <li>• Younger than 21 — once per year</li> <li>• 21 and older — once every 2 years</li> </ul> <p>More visits may be allowed, depending on the symptoms or medical condition.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Vision examinations</li> <li>• Prescription lenses</li> <li>• Cataract removal</li> <li>• Prosthetic eyes are covered for all members</li> <li>• Ophthalmologic exam with refraction</li> <li>• Visual aids (eyeglasses)</li> <li>• Contact lenses and miscellaneous vision supplies (if medically necessary)</li> </ul> <p>Advantica provides this care for you. Call Customer Service to:</p> <ul style="list-style-type: none"> <li>• Find a provider</li> <li>• Make an appointment</li> <li>• Coordinate transportation and translation services</li> </ul> <p>This includes the costs for the lenses, frames or other parts of the glasses. Fittings and adjustments are also covered.</p> <p>New lenses:</p> <ul style="list-style-type: none"> <li>• Younger than 21 — once per year</li> <li>• 21 and older — once every 2 years</li> </ul> <p>Replacement glasses and/or new glasses with major changes in prescription are covered within the benefit periods for both adults and children.</p>

Services	Coverage and Limits
<p><b>Long-Term Care — Home and Community-Based Services</b> Based on your enrollment category as determined by the Department of Human Services, you may be eligible for these additional benefits.</p>	
<p><b>Adult Day Care</b></p>	<p>Adult day care refers to regular supportive care provided to 4 or more disabled adult participants. Services include:</p> <ul style="list-style-type: none"> <li>• Observation and supervision by center staff</li> <li>• Coordination of behavioral, medical and social plans and implementation of the instructions as listed in the participant’s care plan</li> <li>• Therapeutic, social, educational, recreational activities</li> </ul>
<p><b>Adult Day Health</b></p>	<p>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 also includes:</p> <ul style="list-style-type: none"> <li>• Emergency care</li> <li>• Dietetic services</li> <li>• Occupational therapy</li> <li>• Physical therapy</li> <li>• Physician services</li> <li>• Pharmaceutical services</li> <li>• Psychiatric or psychological services</li> <li>• Recreational and social activities</li> <li>• Social services</li> <li>• Speech-language pathology</li> <li>• Transportation services</li> </ul>
<p><b>Assisted Living Services</b></p>	<p>Assisted living services include:</p> <ul style="list-style-type: none"> <li>• Personal care</li> <li>• Supportive care services (homemaker, chore, attendant services and meal preparation)</li> </ul> <p>The health plan is not responsible for payment for room and board.</p>
<p><b>Attendant Care</b></p>	<p>Hands-on care for medically fragile children. The service includes member supervision specific to the needs of a medically stable, physically disabled child. Attendant care may include skilled or nursing care to the extent permitted by law.</p>
<p><b>Community Care Management Agency (CCMA)</b></p>	<p>Covered for members living in community care foster family homes and other community settings, as required.</p>

Services	Coverage and Limits
<p><b>Long-Term Care — Home and Community-Based Services</b> Based on your enrollment category as determined by the Department of Human Services, you may be eligible for these additional benefits.</p>	
<p><b>Community Care Foster Family Home (CCFFH) Services</b></p>	<p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Personal care</li> <li>• Supportive services</li> <li>• Homemaker services</li> <li>• Attendant care</li> <li>• Companion services</li> <li>• Local transportation</li> <li>• Day programming</li> <li>• Medication oversight (to the extent permitted under state law)</li> </ul> <p>All services must be provided in a certified private home by a principal care provider who lives in the home.</p>
<p><b>Counseling and Training</b></p>	<p>Counseling and training activities include the following:</p> <ul style="list-style-type: none"> <li>• Member care training for members</li> <li>• Family and caregivers regarding the nature of the disease and the disease process</li> <li>• Methods of transmission and infection control measures</li> <li>• Biological, psychological care and special treatment needs/regimens</li> <li>• Use of equipment specified in the service plan employer</li> <li>• Skills updates as necessary to safely maintain the individual at home</li> <li>• Crisis intervention</li> <li>• Supportive counseling</li> <li>• Family therapy</li> <li>• Suicide risk assessments and intervention</li> <li>• Death and dying counseling</li> <li>• Substance abuse counseling</li> <li>• Nutritional assessment and counseling</li> </ul> <p>Counseling and training is a service provided to:</p> <ul style="list-style-type: none"> <li>• Members</li> <li>• Families/caregivers on behalf of the member</li> <li>• Professional and paraprofessional caregivers on behalf of the member</li> </ul>

Services	Coverage and Limits
<p><b>Long-Term Care — Home and Community-Based Services</b>            Based on your enrollment category as determined by the Department of Human Services, you may be eligible for these additional benefits.</p>	
<p><b>Environmental Accessibility Adaptations</b></p>	<p>Covered services include:</p> <ul style="list-style-type: none"> <li>• The installation of ramps and grab-bars</li> <li>• Widening of doorways</li> <li>• Modification of bathroom facilities</li> <li>• Installation of specialized electric and plumbing systems (must be necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual)</li> </ul> <p>All services shall comply with state or local building codes.</p>
<p><b>Home-Delivered Meals</b></p>	<p>Includes nutritious meals delivered to a location where an individual resides (excluding residential or institutional settings).            The meals will not replace or substitute for a full day's nutrition (i.e., no more than 2 meals per day).</p>
<p><b>Home Maintenance</b></p>	<p>Home maintenance services are those services not included as a part of personal assistance and include:</p> <ul style="list-style-type: none"> <li>• Heavy-duty cleaning to bring a home up to acceptable standards of cleanliness at the start of service to a member</li> <li>• Minor repairs to essential appliances, limited to stoves, refrigerators and water heaters</li> <li>• Fumigation or extermination services</li> </ul>
<p><b>Medically Fragile Day Care</b></p>	<p>Medically fragile day care is a non-residential service for children who are medically and/or technology dependent.            Covered services include activities focused on meeting the following needs for children:</p> <ul style="list-style-type: none"> <li>• Psychological</li> <li>• Physical</li> <li>• Functional</li> <li>• Nutritional</li> <li>• Social</li> </ul> <p>Services are furnished 4 or more hours a day on a regular schedule for 1 or more days a week in an outpatient setting.</p>

Services	Coverage and Limits
<p><b>Long-Term Care — Home and Community-Based Services</b> Based on your enrollment category as determined by the Department of Human Services, you may be eligible for these additional benefits.</p>	
<p><b>Moving Assistance</b></p>	<p>Help moving is offered when the Service Coordinator finds that a member needs to move to a new home to keep health from getting worse. This includes:</p> <ul style="list-style-type: none"> <li>• Unsafe home due to deterioration</li> <li>• The individual is wheelchair bound, living in a building with no elevator, multistory building with no elevator or where the client lives above the first floor</li> </ul> <p>Moving expenses include packing and moving of belongings.</p>
<p><b>Personal Assistance Services — Level 2</b></p>	<p>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:</p> <ul style="list-style-type: none"> <li>• Personal hygiene and grooming, including bathing, skin care, oral hygiene, hair care and dressing</li> <li>• Help with bowel and bladder care</li> <li>• Help with mobility</li> <li>• Help with transfers</li> <li>• Help with medications</li> <li>• Help with routine or maintenance health care services by a personal care provider</li> <li>• Help with feeding, nutrition, meal preparation and other dietary activities</li> <li>• Help with exercise, positioning and range of motion</li> <li>• Taking and recording vital signs, including blood pressure</li> <li>• Measuring and recording intake and output, when ordered</li> <li>• Collecting and testing specimens as directed</li> </ul>
<p><b>Personal Emergency Response Systems (PERS)</b></p>	<p>PERS are devices to help members who are at a high risk of having to go the hospital. They can get help in case of an emergency.</p> <ul style="list-style-type: none"> <li>• PERS items include electronic devices or services designed for emergency assistance</li> </ul> <p>PERS services are limited to those individuals:</p> <ul style="list-style-type: none"> <li>• Who live alone</li> <li>• Who are alone for significant parts of the day</li> <li>• Who have no regular caregiver for extended periods</li> <li>• Who would otherwise need extensive routine supervision</li> </ul> <p>PERS services will only be offered to a member living in a non-licensed setting.</p>

Services	Coverage and Limits
<p><b>Long-Term Care — Home and Community-Based Services</b> Based on your enrollment category as determined by the Department of Human Services, you may be eligible for these additional benefits.</p>	
<p><b>Private-Duty Nursing</b></p>	<p>Covered for those who need on-going nursing care. The service is provided by licensed nurses within the scope of state law.</p>
<p><b>Licensed Residential Care</b></p>	<p>Residential care is provided in a licensed private home by a principle care provider who lives in the home. He or she gives the following services to members:</p> <ul style="list-style-type: none"> <li>• Personal care services</li> <li>• Homemaker, chore, attendant care and companion services</li> <li>• Medication oversight (to the extent allowed by law)</li> <li>• Transportation to medical appointments</li> </ul>
<p><b>Respite Care</b></p>	<p>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:</p> <ul style="list-style-type: none"> <li>• Member’s home or place of residence</li> <li>• Foster home or expanded-care adult residential care home</li> <li>• Medicaid-certified nursing facility</li> <li>• Licensed respite day care facility</li> <li>• Other community care residential facility approved by the Plan</li> </ul> <p>Respite care services are authorized by the member’s PCP as part of the member’s care plan.</p>
<p><b>Specialized Medical Equipment Warranty and Supplies</b></p>	<p>Refers to the purchase, rental, lease, warranty and supplies costs, installation, repairs and removal of devices, controls or appliances specified in the care plan. This also includes:</p> <ul style="list-style-type: none"> <li>• Items necessary for life support</li> <li>• Supplies and equipment needed for the proper functioning of such items</li> <li>• Durable and non-durable medical equipment not available under the Medicaid state plan</li> </ul> <p>Examples include:</p> <ul style="list-style-type: none"> <li>• Specialized infant car seats</li> <li>• Modification of parent-owned motor vehicle to accommodate the child, i.e., wheelchair lifts</li> <li>• Intercoms for monitoring the child’s room</li> <li>• Shower seat</li> <li>• Portable humidifiers</li> <li>• Electric bills specific to electrical life support devices (ventilator, oxygen concentrator)</li> <li>• Medical supplies</li> </ul>

Services	Coverage and Limits
<p><b>Long-Term Care — Institutional Services</b> Based on your enrollment category as determined by the Department of Human Services, you may be eligible for these additional benefits.</p>	
<p><b>Nursing Facility Services</b></p>	<p>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 para-medical personnel.</p> <p>The care that is provided in a nursing facility includes:</p> <ul style="list-style-type: none"> <li>• Independent and group activities</li> <li>• Meals and snacks</li> <li>• Housekeeping and laundry services</li> <li>• Nursing and social work services</li> <li>• Nutritional monitoring and counseling</li> <li>• Pharmaceutical services and rehabilitative services</li> </ul>

Non-Covered Services	Exceptions/Limits
<p><b>Behavioral Health</b></p>	<p>Members:</p> <ul style="list-style-type: none"> <li>• Whose diagnostic, treatment or rehabilitative services are determined not to be medically necessary by the health plan</li> <li>• Who are receiving specialty mental health services under other DOH behavioral health programs</li> <li>• Who have been criminally committed for evaluation or treatment in an inpatient setting under the provisions of Chapter 706, HRS</li> </ul>
<p><b>Cosmetic Procedures</b></p>	<p>Not covered</p>
<p><b>Home Health Services</b></p>	<p>Medicaid home health services will not be covered when they are already covered by Medicare home health benefits.</p>
<p><b>Hysterectomies</b></p>	<p>Not covered when:</p> <ul style="list-style-type: none"> <li>• Performed solely for the purpose of rendering a member permanently incapable of reproducing</li> <li>• There is more than 1 purpose for performing the hysterectomy (but the primary purpose is to render the member permanently incapable of reproducing)</li> <li>• It is performed for the purpose of cancer prophylaxis</li> </ul>
<p><b>Investigational and Experimental Procedures</b></p>	<p>Not covered</p>

Non-Covered Services	Exceptions/Limits
<b>Medical Care in a Foreign Country for Children or Adults</b>	Not covered
<b>Intentional Termination of Pregnancy</b>	Not covered
<b>Radiology/ Laboratory/Other Diagnostic Services</b>	<p>Non-covered services include:</p> <ul style="list-style-type: none"> <li>• Radiology services — ultrasounds for gender determination</li> </ul> <p>Laboratory and diagnostic services:</p> <ul style="list-style-type: none"> <li>• Experimental</li> <li>• Investigational or generally unproven</li> <li>• IgG4 testing</li> <li>• Procedures related to storing, preparation and transfer of oocytes for in vitro fertilization</li> </ul>
<b>Transplant Services</b>	<p>May be covered by DHS through the State of Hawai'i Organ and Tissue Transplant (SHOTT) Program. State limits transplant coverage to non-experimental, non-investigational procedures for the specific organ/tissue and specific medical condition.</p> <p>We will assist with a referral to the SHOTT Program when medically appropriate.</p>
<b>Vision Services</b>	<p>Non-covered services include:</p> <ul style="list-style-type: none"> <li>• Orthoptic training</li> <li>• Prescription fee, progress exams</li> <li>• Radial Keratotomy, visual training and Lasik procedure</li> <li>• Contacts for cosmetic reasons</li> </ul>

## **PRESCRIPTION DRUG SERVICES**

### **Prescriptions and Pharmacy Access**

#### **? How do I get a prescription?**

Prescriptions must be written by a plan doctor.

#### **? Which drug stores will fill my prescription?**

Prescriptions must be filled at a drug store in our network. A list of these drug stores is in your provider directory and at [www.ohanahealthplan.com](http://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. There may be a co-pay if you have other insurance coverage such as Medicare.

### **Preferred Drug List**

#### **? What medicines do we pay for?**

'Ohana pays for medicines on our Preferred Drug List (PDL). Doctors and pharmacists make the list. Your PCP will use the list when prescribing drugs for you. Some drugs will require approval through a Coverage Determination Request (CDR) that is done by your doctor. (This applies to drugs that require prior authorization and those drugs not listed on the PDL.) The list will also have drugs that may have limits such as prior authorization, quantity limits, step therapy, age limits or gender limits. If you would like to see the list, it is on our website. Go to [www.ohanahealthplan.com](http://www.ohanahealthplan.com). You can also call Customer Service to request that a printed PDL 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 anorexia or weight gain
- Those used for erectile dysfunction
- Those that are used for cosmetic purposes or to help you grow hair
- Vitamins, except for prenatal vitamins and those listed on the PDL
- DESI (Drug Efficacy Study Implementation) drugs and drugs that are identical, related or similar to such drugs
- Investigational or experimental drugs

#### **? Can I get any medicine I want?**

You will get all medicines that are medically necessary. All drugs your doctors order for you may be covered if they are on the Preferred Drug List (see above). Call Customer Service with any questions. In some cases, we require you to try another drug before approving the one you originally asked for. We may not approve your requested drug if you do not try the alternative drug first.

#### **? Are generic drugs as good as brand-name drugs?**

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

## **Over-the-Counter (OTC) Drugs**

### **? Do we pay for OTC drugs?**

'Ohana pays for some OTC drugs. All OTC drugs covered on our plan require a prescription. We pay for these items:

- Aspirin
- Ibuprofen
- Diphenhydramine
- Non-sedating antihistamines
- Insulin
- Insulin syringes
- Urine test strips
- Antacids
- H-2 receptor antagonist
- Proton pump inhibitors
- Multivitamins/multivitamins with iron
- Iron
- Topical anti-fungals

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 drug store. You may then submit a claim form and your receipts to recover your costs. This is called Direct Member Reimbursement, or DMR.

### **? Where do I send my request?**

'Ohana 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, days 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 DMR will be denied. You will then be able to send in your request again with the missing information.

### **? How much will I get back?**

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

### **? How long should I expect to wait for my reimbursement?**

It usually takes four to six weeks from the date you mail in the DMR Form. Be sure that 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 Appeals Procedures section of this handbook for more information on your right to appeal.

### **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 will look at another way to meet your NET needs. On O'ahu, there are two options — bus and Handi-Van services. We will provide you with bus passes or Handi-Van passes to get you to appointments. On all other islands, bus service will be used if available.

Bus service will be used:

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

If you live on O'ahu, you may be able to ride the Handi-Van. This service is for persons with disabilities unable to ride the bus. Handi-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 the Handi-Van. The Handi-Van Eligibility Center is located at: **The First Insurance Center, 1100 Ward Avenue, Suite 835, Honolulu, HI 96814-1613**

The center is open Monday through Friday from 8:30 a.m. to 4 p.m. Please call **1-808-538-0033** for more information or to schedule an in-person interview.

What if your Service Coordinator and medical provider say you are unable to ride the bus or Handi-Van? Or what if these services aren't available in your area? Then we will work with you to find another way to get you where you need to go.

Talk with your provider about ongoing appointments. He or she can request NET for you.

Here are some things to remember about NET services:

You need to set up your transportation at least 72 hours (three days) before your appointment.

If you ask for a ride less than 72 hours before your appointment, we will decide if it is an urgent need. (We will use the state's definition of urgent to decide.) We will get you a ride if we decide it is urgent. We may ask you to reschedule your appointment if you repeatedly ask for NET less than 72 hours in advance.

Contact our vendor, (Logisticare), to schedule NET. Call them at **1-866-790-8858**. You can also call Customer Service for help.

NET services are for medical appointments. Non-medical transportation (for example, trips to the pharmacy, support groups or community events) is not a covered benefit.

## **DISEASE MANAGEMENT**

‘Ohana has disease management programs to help you better understand and manage your chronic health condition. The goals of the programs are to:

- Provide you with 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 chronic diseases:

- Diabetes mellitus
- Obesity management
- Coronary artery disease
- Depression
- Smoking cessation

All members with these chronic diseases may join this program at no cost. Your Service Coordinator or provider also may refer you to the Disease Management program. Or you may enroll directly at any time. This program is meant to enhance the care you receive from your provider, not replace any service.

To learn more, you may contact Customer Service at 1-888-846-4262 and ask for the Disease Management department. TTY/TDD users call 1-877-247-6272.

## **BEHAVIORAL HEALTH SERVICES**

We can help you get an outpatient mental health or substance abuse assessment for you or someone in your family. Call your Service 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 are having any of these problems. We can get you an assessment from 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, stomach and backaches

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

### **What to Do in an Emergency or If You Are Out of Our Service Area**

First, decide if it is a true behavioral health emergency. Do you think that 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 behavioral health care outside our service area, please tell us. Just call the number on your ID card. You should also call your PCP if you can. Call your PCP again in 24 to 48 hours. Once you are stable, plans will be made to transfer you to 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 emergency services section on page 33 for more details. For outpatient or inpatient services, your PCP specialist will request a prior authorization.

### **OTHER PROGRAMS**

‘Ohana 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 will need to make a referral for you to get certain services. These include:

- Services that your PCP does not perform
- Specialist visits at an office or free-standing clinic

### **SERVICES AVAILABLE WITHOUT A REFERRAL (SELF-REFERRAL SERVICES)**

You do not need approval from your PCP or the plan for these services:

- Emergency and urgent care services
- Family planning services
- Routine checkups and treatment from your assigned PCP
- Routine diagnostic tests
- Lab tests
- Basic radiology services
- Well-child, EPSDT and treatment visits for children up until their 21st birthday
- Annual wellness visit for women, including a Pap smear
- Routine vision
- Behavioral health
- Disease Management

You can go to any ‘Ohana provider to receive the services listed above. Just call the provider you choose and set up an appointment. Tell them that you are an ‘Ohana member and show them your ID card at your visit.

You can find a list of providers on the Web. Just visit [www.ohanahealthplan.com](http://www.ohanahealthplan.com). You can also call Customer Service to ask for a directory.

## **SERVICES FOR PROVIDERS NOT IN NETWORK**

There may be times when the health care you need is not available using a provider who is a part of 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. This includes family planning services.

## **SERVICES THAT REQUIRE PRIOR AUTHORIZATION**

We need to approve the following services before you can get them. This is called prior authorization. Your PCP or specialist will contact us to ask for this approval. If we do not approve them, we will notify you. We will give you information about the grievance and appeals process and your right to a state hearing.

This list may change. You can go to [www.ohanahealthplan.com](http://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
- Most medical tests done by your PCP or specialist
- Referrals to a case management agency and/or foster home placement
- Cardiac and pulmonary rehabilitation programs
- Chemotherapy
- Surgical procedures
- Cosmetic procedures
- Investigational and experimental procedures and treatments
- Non-emergency hospital services

We will approve regular service within 14 days. We or your doctor may need more time to make this decision. If so, we will then take 14 more days. You or your doctor can ask us for a fast decision (a decision made within 24 hours). You may ask for this if waiting for an approval could put your life or health in danger. Sometimes we will need more time to make a fast decision. This can mean up to five 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 health care and services you receive. We measure this based on your health plan coverage. We check to see if the care and services are provided at the right place and at the right time. Then we determine how much coverage we can provide according to your benefits. And we decide on how to pay those who provide the care.

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

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, you may contact Customer Service at 1-888-846-4262. TTY/TDD users call 1-877-247-6272.

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

If the health plan objects to providing a service on moral or religious grounds, we will furnish information about the services it does not cover:

- To the DHS within 120 days of adopting the policy
- To members before and during enrollment
- To members within 90 days after adopting the policy with respect to any particular service

## **SECOND MEDICAL OPINION**

Call your PCP to get a second opinion about your care. He or she will ask you to pick a plan doctor in your area. If you can't find another plan doctor in your area, your PCP will ask you to pick a doctor who is not in our network if you can't find a plan doctor in your area. Your PCP will get authorization for this visit. You don't pay for these services. You can also call Customer Service to help you with getting a second opinion.

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

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

## **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 can go to an urgent care center.

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

## **EMERGENCY SERVICES**

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

### **What to Do in an Emergency**

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

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

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

- Placing the physical or mental health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

- Serious harm to yourself or others due to an alcohol or drug abuse emergency
- Injury to yourself or bodily harm to others
- A threat to the health or safety of a pregnant woman or her unborn child

When you get to the emergency room (ER), you will need to show your 'Ohana ID card. Let your PCP know as soon as you can when you are in the hospital and let him or her know if 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 it is not, you get the choice to stay. If you stay when it is not an emergency, you must pay for the care.

You don't need prior approval for emergency services or follow-up care. This is true whether it's within or outside our network.

### **Post-Stabilization Services**

It is important that you get care until your condition is stable. We will pay for care you get after your emergency room care. This is called post-stabilization care. You do not need pre-approval for post-stabilization services. But this care must be done to maintain, improve or solve your medical condition.

### **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 you get while you are out of the service area, write to our claims department. They will need copies of your medical reports and the bills. They will also need proof of payment.

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

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

### **WHAT TO DO IF YOU NEED URGENT CARE**

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

- Injury
- Illness
- Severe pain

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

Let your PCP know if you get care in an urgent care center. That way, he or she can give you follow-up care.

### **OUT-OF-STATE AND OFF-ISLAND COVERAGE**

We cover any medically necessary covered services that are not available in the state or island where you live. If you or your provider decide that you need a service out-of-state or off-island, just contact us. We will work with you to try to obtain the service locally. We will provide these services out of state or off island if needed.

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 any needed attendant

If you get sick or hurt or need medically necessary EPSDT (for members under 21) services while you are out of the 'Ohana service area, and it is not an emergency, call Customer Service. Call toll-free **1-888-846-4262** (TTY/TDD: **1-877-247-6272**). We will help arrange the care you need and ensure you get approval before receiving services.

If you have an emergency out of state or off island, go to a hospital. Show your ID card. Call your PCP as soon as you can. Ask the hospital staff to call 'Ohana. If you have to pay for care you get while you are out of the service area, call Customer Service for assistance. You will need copies of your medical reports and the bills. You will also need proof of payment. You have up to one year to request a reimbursement.

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

### **PREGNANCY AND NEWBORN CARE**

We cover our members throughout their pregnancy and for the first 30 days after 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 QExA and you do not choose a plan within 15 days, your baby will be assigned to 'Ohana. If your baby is eligible for QUEST and you do not choose within the allowed time, your baby will be assigned to a QUEST health plan.

Moms-to-be should set up a visit with an 'Ohana OB (obstetrics) doctor. Do this within 14 days of signing up for the plan or finding 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. You will also need to choose a PCP for your baby. You should do this by the time the baby is born. If you do not choose, we will assign one.

### **TRANSITION OF CARE**

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

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

Please call Customer Service or your service coordinator to help arrange the care you need.

### **COMMUNITY-BASED SERVICES**

Hawai'i has several programs that you and/or child may qualify for. These programs are offered in the community. They are not 'Ohana benefits. However, you can call your Service Coordinator for help with getting into these programs.

### **MENTAL HEALTH/BEHAVIORAL HEALTH SERVICES**

You may qualify for more services if you or your child has a mental health disorder. These are in addition to the services provided by 'Ohana.

For referrals for adult services, call your Service Coordinator. He or she will be able to help you start the process. You can also call the Adult Mental Health Division (AMHD) Access line toll-free at **1-800-753-6879** (on O'ahu, call **832-3100**).

Referrals for children (to age 21) go through your local school's Family Guidance Center. Your Service Coordinator can help with this. The Family Guidance Centers are:

Family Guidance Center	Location	Phone Number
Central O'ahu	Pearl City	453-5900
Family Court Liaison Branch	Kailua	269-9922
Honolulu	Honolulu	733-9393
Leeward O'ahu	Kapolei	692-7700
Windward Kane'ohe	Kane'ohe	233-3770
Hawai'i		
• Hilo	Hilo	933-0610
• Waimea	Kamuela	887-8100
• Kona	Kona	322-1541
Kaua'i	Lihu'e	274-3883 ext. 231
Maui		
• Wailuku	Wailuku	243-1252
• Lahaina	Lahaina	662-4045
• Lana'i	Lana'i City	565-7915
• Moloka'i	Kaunakakai	553-5067

## DEVELOPMENTAL DISABILITY WAIVER PROGRAM

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

- Developmental disability
- Mental retardation

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

- 586-5840 in Honolulu, O'ahu
- 241-3406 in Lihu'e, Kaua'i
- 243-4625 in Wailuku, Maui
- 974-4280 in Hilo, Hawai'i

You may also call your Service Coordinator.

## ADDITIONAL SERVICES FOR CHILDREN

'Ohana has an EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Program. It provides needed care for children to age 21. (Please see the *Well-Child Care and EPSDT Services* section later in this book.)

Children may qualify for more services with these programs.

- The Zero to Three Program for children with suspected (developmental) delays — call Hawai'i Keiki Information Service System 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) — call 1-888-820-6425 (on O'ahu, call 586-8175)

Your Service Coordinator can help you with these. Call him or her to learn more.

## **WOMEN, INFANTS AND CHILDREN (WIC) PROGRAM**

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

- Nutrition education
- Nutritious food
- Support for breastfeeding mothers
- Health care referrals

Members who are pregnant should ask their doctor to complete a WIC application. Or they can visit their local health department.

## **WELL-CHILD CARE AND EPSDT (EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT) SERVICES**

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

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

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

### **? What is a well-child checkup?**

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

- Do a comprehensive head-to-toe physical and 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 he or she needs during these visits.

### **? When should a well-child checkup occur?**

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

- 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
- Every year during ages 2–6 years old
- Even years between the ages 6–20

### **? How much does a well-child checkup cost me?**

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

### **? What if I need help getting a doctor visit?**

We can help you get an appointment. Just call Customer Service.

### **? What if I need help getting to the doctor visit?**

We can help you get a ride to the doctor. Call Customer Service.

## **PREVENTIVE HEALTH GUIDELINES**

On the next few pages of this book, you will find guidelines. 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 for an appointment.

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

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

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

## PEDIATRIC PREVENTIVE HEALTH GUIDELINES—NEWBORN UP TO 21 YEARS OLD

Age	Well-Baby Checkups and Shot Guide
Newborn	Well-baby checkup* at birth Hearing screening Newborn screening blood tests and Hepatitis B (HepB) vaccine
3–5 days	Well-baby checkup* as recommended by your doctor, including newborn screening blood tests and Hepatitis B (HepB) vaccine if not done at birth (this visit is especially important if your baby was sent home within 48 hours of birth)
1 month	Well-baby checkup* Second dose of HepB vaccine, TB screening Newborn screening blood test if not already completed
2 months	Well-baby checkup* Diphtheria, Tetanus, and Pertussis (DTaP), Rotavirus (RV), Polio (IPV), Pneumococcal conjugate (PCV) and Haemophilus influenzae type b (Hib) vaccines Newborn screening blood test if not already completed
4 months	Well-baby checkup* DTaP, Hib, IPV, PCV and RV vaccines, Hemoglobin (Hgb) screening
6 months	Well-baby checkup* DTaP, HepB, IPV, PCV, influenza, Hib and RV vaccines Blood lead risk assessment TB screening Begin yearly flu shot if fall or winter Oral health screening
9 months	Well-baby checkup* Blood lead test/risk assessment, Developmental screening Oral health screening
12 months	Well-baby checkup* Blood lead test, hemoglobin or hematocrit (if not done at 9-month visit) Hib, Measles, Mumps, Rubella (MMR), hepatitis A (HepA) (first shot between 12 and 23 months), varicella (chickenpox), PCV (between 12 and before 15 months) and influenza vaccines Dental visit as need identified by your doctor** Yearly flu shot if not done at 6-month visit TB screening
15 months	Well-baby checkup* DTaP vaccine (between 15 to 18 months)

Age	Well-Baby Checkups and Shot Guide
18 months	Well-baby checkup* Second dose of HepA vaccine (6 months after the first dose) Lead screening, autism screening, developmental screening Dental visit Yearly flu shot if not done annually TB screening
24 months	Well-baby checkup* Blood lead test Influenza vaccine (during fall or winter) Autism screening TB screening Dyslipidemia screening Dental visit
30 months	Well-baby checkup* Vision and hearing screenings Dental visit Developmental screening
3 years	Well-child checkup* Eye screening Dental visit twice a year Influenza vaccine TB screening Lead test if none were performed at ages 12 and 24 months
4–5 years	Well-child checkup* every year Eye screening between 4–5 years Hearing screening Dental visit twice a year Urine test at age 5 years DTap, IPV, MMR, varicella and influenza vaccines Lead test if none were performed at ages 12 and 24 months TB screening Dyslipidemia screening

Age	Well-Child Checkups and Shot Guide
6–20 years (even years)	Well-child checkup* every other year Lead screening (6 years) Dyslipidemia screening (even years to 10 then annually) Dental visit twice a year Eye screening (even years until 12 then at 15 and 18) Hearing Test (6, 8, 10) Influenza vaccine every year during fall or winter Human papillomavirus vaccine (HPV) at a minimum age of 9 years
11–12 years	Well-child checkup* every other year as above, plus: Meningococcal conjugate vaccine (MCV), Tetanus, diphtheria and pertussis (Tdap), HPV series three times, influenza vaccine every year STI screening Dental visit twice a year
12–14 years (females only)	Well-adolescent checkup* every other year, plus: Females should have a pelvic exam and Pap smear between 18 and 21 years, Hemoglobin test, STI screening

NOTES:

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

\*\* Dental visits may be recommended beginning at age 6 months.

This is just a guide. It does not replace your doctor’s advice. Talk with your doctor to make sure you and your family get the right tests and care.

**For children with asthma:**

If your child has not seen his or her doctor in the past three months, call and 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.

**For children with diabetes:**

If your child has diabetes and has not seen their doctor in the past 3 months, call and make an appointment. This will help your child stay healthy and avoid additional health problems from diabetes. National guidelines recommend all diabetics be seen every three months, and have the following tests done:

**Blood sugar average** — done at least yearly — called **hemoglobin A1c (HbA1c)**. The result should be less than 7 percent.

**LDL cholesterol** — done at least yearly. You may need treatment if your LDL results are greater than 100mg/dL.

**Dilated Eye Exam** — done yearly by an eye doctor to check for diabetic retinopathy.

**Foot exam yearly.**

Urine **test for protein and microalbumin** — done yearly to check how well your kidneys are working.

References:

- 2010 Bright Futures/American Academy of Pediatrics ([www.aap.org](http://www.aap.org)).
- Committee on Practice and Ambulatory Medicine Recommendations for Preventive Pediatric Health Care, PEDIATRICS, Vol. 105 (3), March 2000, pages 645–646, Copyright © 2000 by the AAP.
- Recommended Immunization Schedules for Persons Ages 0–18 Years—United States, 2010 approved by the Advisory Committee on Immunization Practices (ACIP) <http://www.cdc.gov/vaccines/recs/schedules/childschedule.htm#printable>, the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).
- Catch-up Immunization Schedule for Persons Aged 4 Months through 18 Years Who Start Late or Who Are More Than 1 Month Behind, United States-2009, approved by the Advisory Committee on Immunization Practices ([www.cdc.gov/nip/acip/](http://www.cdc.gov/nip/acip/)), 2008 Bright Futures/American Academy of Pediatrics ([www.aap.org](http://www.aap.org)) and the American
- Academy of Family Physicians ([www.aafp.org](http://www.aafp.org)).
- American Dental Association ([www.ada.org](http://www.ada.org)).

Version: 2/2010 (revised)

## ADULT PREVENTIVE HEALTH GUIDELINES

### Frequency of Physical Examination

All new members should get a baseline physical exam in the first 90 days of enrollment. Pregnant members should be seen in the first 30 days. The Cleveland Clinic’s recommendations for periodic health exam visits for asymptomatic adults are:

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

Age	Screening	Frequency
18 years of age and older	Blood pressure, height, body mass index (BMI), alcohol use	Each year from age 18 to 21. Then, every 1 to 2 years or at PCP’s recommendation.
Men 35 to 65 years of age	Cholesterol (non-fasting TC/HDL)	Every 5 years (more often if elevated)
Women 45 to 65 years of age	Cholesterol (non-fasting TC/HDL)	Every 5 years (more often if elevated)
High-risk men and women 20 years of age and older	Cholesterol (non-fasting TC/HDL)	Every 5 years (more often if elevated)

Age	Screening	Frequency
Women 18 to 25 years of age who are sexually active (consider at age 12 if sexually active)	Chlamydia	Each year and at PCP's recommendation
Women 18 to 65 years of age (or 3 years after onset of sexual activity, whichever comes first)	Pap smear	Every 1 to 3 years
Women 40 years of age and older	Mammography	Every 1 to 2 years
50 years of age and older	Colorectal	Periodically depending upon test (e.g., colonoscopy every 10 years if low risk, 2 years if high risk)
Women 65 years of age and older (60 and older if at risk for fractures)	Osteoporosis	Bone mass measurement every 2 years
65 years of age and older	Vision, hearing	Periodically

#### Immunizations

Tetanus-Diphtheria and acellular pertussis (Td/Tdap)	19 years of age and older, Tdap — substitute 1-time dose of Tdap for Td then boost with Td every 10 years
Varicella (VZV)	All adults without evidence of immunity to varicella should receive 2 doses of single-antigen varicella vaccine if not previously vaccinated, or the second dose if they have received only 1 dose, unless they have a medical contradiction
Measles, Mumps, Rubella (MMR)	Adults born during or after 1957 should receive 1–2 doses, unless they have a medical contradiction
Pneumococcal polysaccharide (PPSV)	65 years of age and older — 1 dose
Seasonal Influenza	Every year, 50 years of age and older
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 — 3 doses

## Immunizations

Meningococcal conjugate vaccine (MCV)	College freshmen living in dormitories not previously vaccinated with MCV and others at risk, 18 years of age and older — 1 dose (meningococcal polysaccharide vaccine is preferred for adults older than 56 years of age)
Human-papillomavirus (HPV) *	For eligible members through 26 years of age (3-dose series)
Zoster	60 years of age and older — 1 dose, unless a member has a medical contradiction
Haemophilus influenza type b (Hib)	For eligible members who are at high risk and who have not previously received Hib vaccine (1 dose)

## Prevention

Discuss aspirin to prevent cardiovascular events	Men — 40 years of age and older Women — 50 years of age and older
Discuss the importance of preventive exams (mammograms and breast self-examination for women at high risk and who have a family history)	
Discuss prostate specific antigen (PSA) test and rectal exam (for men 40–75 years of age, per PCP's discretion)	

## Counseling

Calcium — 1,000mg a day for women 18 to 50 years of age; 1,200 to 1,500mg a day for women 50 years of age and older
Folic acid — 0.4mg a day for women of childbearing age; 4mg a day for women who have had children with Neural Tube Defects (NTDs)
Breastfeeding — women after giving birth
Quitting tobacco; drug and alcohol use; STDs and HIV; nutrition; physical activity; sun exposure; oral health; injury prevention; polypharmacy

### References:

- Guide to Clinical Preventive Services, 2007: Recommendations of the U.S. Preventive Services Task Force, 2007.
- Press Release CDC's Advisory Committee Recommends Human Papillomavirus Virus Vaccination June 29, 2006.
- Recommended Adult Immunization Schedule — United States, 2010.
- Third Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) May 2001.
- Bone Health and Osteoporosis: A Report of the Surgeon General (2004).

- Cleveland Clinic ([www.cchs.net/health/health-info](http://www.cchs.net/health/health-info)) Periodic Health Exams and Cancer Screening.
- ACG Recommendations on Colorectal Cancer Screening for Average and Higher Risk Patients in Clinical Practice, April 2008.

\* Subject to individual state coverage.

Legal Disclaimer: Preventive health guidelines are based on information and recommendations of independent third parties available before printing. These guidelines are not a replacement for your doctor's medical advice. Your doctor may have more up-to-date information. Members should always talk with their doctor(s) about what care and treatment is right for them. The fact that a service or item is in these guidelines is not a guarantee of coverage or payment. Members should look at their own plan coverage papers to see what is or is not a covered benefit. 'Ohana does not offer medical advice or provide medical care, and does not guarantee any results or outcomes. 'Ohana does not warrant or guarantee, and shall not be liable for any information that is in these guidelines or that is not in these guidelines or for any recommendations made by independent third parties from whom any of the information was obtained.

Version: 2/2010 (revised)

## **ADVANCE DIRECTIVES**

### **YOUR CARE IS YOUR DECISION**

The law says you have a right to refuse medical treatment. This includes life-prolonging care. As your health plan, we have 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 are not able to tell them yourself. Whether or not you have an advance directive will not affect the type of care you receive.

There are two types. One is a living will. The other is a durable power of attorney for health care decisions.

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

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

#### **? Where can I get an advance directives form?**

You can call a lawyer or your local legal aid office. You can also ask your provider or call Customer Service. Call 1-888-846-4262 (TTY/TDD: 1-877-247-6272).

#### **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 health care facility to put into your medical record. Give one to a trusted family member or friend. Keep a copy with your personal papers. You may want to give one to your lawyer or clergy person. Be sure to tell your family or friends — 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, he or she will help you find someone else who will follow your wishes. In addition, health care facilities are not required to implement an advance directive if there is an institution-wide conscientious objection and state law allows such an objection. Other than for conscience reasons, your wishes should be followed. Any reports of non-compliance can be filed with the Med-QUEST Division:

**Med-QUEST Division**  
**Health Care Services Branch**  
**P.O. Box 700190**  
**Kapolei, HI 96709-0190**  
**1-808-586-5390**

## **MEMBER GRIEVANCE AND APPEAL PROCEDURES**

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

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

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

### **? What is a grievance?**

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

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

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

### **? How do I file a grievance?**

You or another person can file a grievance by calling or writing to us. Your doctor or another provider can also file a grievance for you if you authorize them to do so.

You must tell us that you agree to have someone else talk for you about your grievance. Call Customer Service at 1-888-846-4262 (TTY/TDD: 1-877-247-6272).

Or, write to:

**‘Ohana Health Plan**  
**Attn: Grievance Department**  
**P.O. Box 31384**  
**Tampa, FL 33631-3384**

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

## QEXA OMBUDSMAN PROGRAM

The QExA Ombudsman program is available to all members to:

- Ensure access to care
- Promote quality of care
- Help achieve member satisfaction with the QExA program

Contact the Hilopa'a Family to Family Health Information Center to learn more. You can call, e-mail or fax.

Island	Phone Number
O'ahu	1-808-791-3467
Hawai'i	1-808-333-3053
Maui and Lana'i	1-808-270-1536
Moloka'i	1-808-660-0063
Kaua'i	1-808-240-0485
E-mail: <a href="mailto:qexa@hilopaa.org">qexa@hilopaa.org</a>	
Fax: 1-808-531-3595	

You can also visit their website. Go to <http://hilopaa.org/qexa.aspx>.

## STATE GRIEVANCE REVIEW

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

Med-QUEST Division

Health Care 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

(TTY: 1-800-603-1201)

Someone will review the grievance and respond within 30 days of getting it.

### ? What is an appeal?

An appeal is a request you can make when you do not agree with our decision about the health care 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 request 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 health care services you get
- If we fail to give services in the required timeframe
- If we fail to give you a decision on an appeal you already filed in the required timeframe
- If we fail to give you resolution on a grievance in the required timeframe
- 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

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

### **? How do I file an appeal?**

You must file your appeal within 30 days from the date you receive your Notice of Action. You can file by calling or writing to us. If you file by calling, you must follow up with a written, signed appeal. If needed, we can help you file your appeal. You can also get help from others. Your provider or someone else you choose to act for you can help. They can file for you if you give them your written permission. Call Customer Service at 1-888-846-4262 (TTY/TDD: 1-877-247-6272). Or write to us at:

'Ohana Health Plan  
Attn: Appeals Department  
P.O. Box 31368  
Tampa, FL 33631-3368

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

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

You or your doctor can ask for a fast appeal. We will give you a fast appeal if your doctor says waiting could seriously harm your health. You may ask for a fast appeal without a doctor's help. We will decide if you need a fast decision. You or your provider must call or fax us to ask for a fast appeal. Call 1-888-846-4262 (TTY/TDD: 1-877-247-6272). Fax to 1-866-201-0657. 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 timeframe for standard resolution
- Make reasonable efforts to try to call you
- Follow up within two days of written notice
- Inform you verbally and in writing that you may file a grievance about the denial of the expedited process

To request a State grievance review, please contact the State of Hawai'i. Call 1-808-692-8094. Or write to:

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

### **? 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.

You can also ask us for up to 14 more days for you to provide more information. We may also ask for 14 more days if we feel more information is needed and it is in your best interest.

### **? What if I do not like an appeal decision?**

You may not like the appeal decision we make. If so, you can ask for a State Administrative Hearing and/or an external review with the State of Hawai'i's Insurance Commissioner. Someone you choose to act for you can also ask for one. You must do this within 30 days of receipt of the appeal decision letter. The letter will tell you how to file an appeal with the Hawai'i Med-QUEST Division. You can only ask for a 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

At the State Administrative Hearing, you may represent yourself. However you may also use legal counsel, a relative, a friend or other spokesperson to represent you. The state will make a decision within 90 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:

- You request that we continue your services.
- Your appeal or request for State administrative hearing is filed in a timely manner, defined as on or before the later of the following:
  - Within 10 days of the date we mailed you the notice of action
  - The date we planned to stop or reduce your service(s)
- Your appeal or request for 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 period covered by the approval we gave has not ended yet.

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.

An external review is an independent review of our decision.

The Insurance Commissioner's Office must get this request within 60 days from the date of our determination. This request may be sent to the following address:

Department of Commerce and Consumer Affairs Insurance Division  
Health Insurance Branch  
P.O. Box 3614, Honolulu, HI 96811  
Telephone: 1-808-586-2804  
Fax: 1-808-587-5379

## **MEDICATION APPEALS**

### **? What if I want to appeal a decision made about a medication? Do I do anything different?**

You can still call Customer Service. (You must follow verbal requests with a signed written request.) But written medication appeals go to a different address. Send your appeal to:

'Ohana Health Plan  
Attn: Pharmacy Medication Appeals Department  
P.O. Box 31398  
Tampa, FL 33631-3398

Or you can fax it to 1-888-865-6531. We will send you a letter within five business days after we get your appeal. It will let you know we received your appeal request. We will not send one if it is a request for a fast appeal.

### **? How soon must I file my medication appeal?**

Appeal within 30 days of the date of our notice to you.

### **? What if I want a fast or expedited medication appeal?**

Send an appeal for a decision we made on a prescription to:

'Ohana Health Plan  
Attn: Pharmacy Medication Appeals Department  
P.O. Box 31398  
Tampa, FL 33631-3398

You can fax it too. Fax an appeal for a prescription to 1-888-865-6531. Don't forget to ask for a fast review. We will give you a fast 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. We will try to call you if we decide your health does not require it. We will also send you a letter within two days. It will say you can get a fast review with a doctor's support. The letter will also tell you how to file a grievance if you disagree and feel you need a fast review. We will give you a standard review if you decide not to do a fast review. This usually takes 30 days.

### ? How soon must we decide on your appeal?

For a standard decision about your prescription — 30 days after we get your appeal. We will make it sooner if your health requires. You can get 14 more days if you ask or if we find information that will help you. You can ask for this extra time by writing to us or calling Customer Service. We will send you a letter if we take extra time. The letter will say why. We will also let you know the date we expect to make a decision.

For a fast decision about your prescription — up to 72 hours after we get your appeal or sooner if your health requires it. You can get 14 more days if you ask or if we find information that will help you. You can ask for this extra time by writing to us or calling Customer Service. We will send you a letter if we take extra time. The letter will say why.

We will also let you know the date we expect to make a decision. We will mail you a letter in each case. It will tell you about your appeal rights if the decision is not in your favor. We will also try to call you about standard decisions.

### ? How will I be notified?

- For a standard decision about your prescription — a written notice will be sent to you
- For a fast decision about your prescription — a reasonable attempt will be made verbally, followed by a written notice

### ? What if I do not like the medication appeal decision?

You may not like the decision. You have the right to ask for a State Administrative Hearing. Please see the *Member Grievance and Appeal Procedures* section for details on this process.

## ENROLLMENT INFORMATION

### ENROLLMENT

People covered under QUEST Expanded Access (QExA) may join 'Ohana. QExA provides acute, behavioral health and long-term care services to persons who are aged, blind or disabled (ABD). Covered groups include:

- ABD individuals living in the community
- ABD individuals residing in long-term care institutions
- ABD individuals enrolled in an existing Home and Community-Based Services program
- Other relatively small, specialized ABD populations

There are certain requirements that you have to meet to be covered under QExA. The Med-QUEST Division (MQD) decides who is eligible. They will let you know how to select a health plan. You will also receive information that will address the basics of managed care and the health plans available to provide care. To learn more about the selection process and how to join a plan, please call the QExA Enrollment Counselors. The number is 1-866-928-1959 (TTY: 1-866-928-1958).

## **90-DAY GRACE PERIOD**

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

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

- An administrative appeal decision
- Provisions in administrative rules or statutes
- A legal decision
- Relocation to a service area where the health plan does not provide service
- An administrative decision for foster children which is the result of an agreement between the DHS, the child welfare service worker and the health plan involved
- The plan’s refusal, because of moral or religious objections, to cover the service you may want
- The need for related services (for example, a cesarean section and a tubal ligation) to be performed at the same time and not all related services are available within the network and your PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk

Other reasons, including but not limited to:

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

## **ANNUAL CHANGE**

Every year, the state will have a period when you can change plans without cause. You will be notified 60 days prior to the effective date of the change. If you do not choose a health plan, the State will choose one for you. Before they do, they will try to contact you. If you do not reply within 15 days, a plan will be chosen for you. For more information, call the QExA Enrollment Counselors at 1-866-928-1959 (TTY: 1-866-928-1958). You can also call ‘Ohana Customer Service at 1-888-846-4262 (TTY/TDD: 1-877-247-6272).

## **REINSTATEMENT**

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

## **INVOLUNTARY DISENROLLMENT**

You may lose your ‘Ohana membership if you:

- No longer qualify based on the medical assistance eligibility criteria
- Voluntarily leave the program
- Die
- Are incarcerated
- Enter the Hawai‘i State Hospital
- Become a PACE or Pre-Pace participant
- Enter the State of Hawai‘i Organ and Tissue Transplant (SHOTT) Program
- Are in foster care and have moved out of state by the DHS

- Become a Medicare Special Savings Program recipient beneficiary
- Provide false information with the intent of enrolling in the program under false pretenses
- Choose another health plan during the annual plan change period

You cannot be disenrolled from the plan for these reasons:

- Pre-existing medical conditions
- Missed appointments
- Changes in health status
- Utilization of medical services
- Diminished mental capacity
- Uncooperative or disruptive behavior resulting from the member's special needs (except where the member's continued enrollment in the health plan seriously impairs the health plan's ability to furnish services to either the member or other members)

## **IMPORTANT INFORMATION ABOUT 'OHANA**

### **OUR SERVICE AREA**

'Ohana serves the following islands:

- Kaua'i
- O'ahu
- Moloka'i
- Maui
- Lana'i
- Hawai'i

If you move, call Customer Service. You will want to pick a PCP near your new home. If you move out of our service area, you must call MQD. The number is 1-800-316-8005. They will be able to help you with your health care needs.

### **PLAN STRUCTURE AND OPERATIONS**

To learn more about the structure and operations of the plan, call Customer Service. Call 1-888-846-4262 (TTY/TDD: 1-877-247-6272).

### **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 will affect how they use referrals. You may also ask if it will affect other services you may need. Call Customer Service for more information.

### **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 the following 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 AND ABUSE**

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

Here are some other examples of fraud and abuse:

- Billing for a more expensive service than what was actually given
- Billing more than once for the same service
- Billing for services not actually performed
- Falsifying a patient's diagnosis to justify tests, surgeries or other procedures that are not medically necessary
- Filing claims for services or medications not received
- Forging or altering bills or receipts
- Misrepresenting procedures performed to obtain payment for services that are not covered
- Over-billing the plan
- Using someone else's '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 know that fraud or abuse has occurred, tell us. If you think that fraud or abuse has occurred, tell us. We will be able to determine if something is fraud or abuse. Call our 24-hour fraud hotline. The toll-free number is 1-866-678-8355. It is private and you may leave a message without leaving your name. If you do leave your phone number, we will call you back. We'll do this to be sure our information is complete and accurate. You can also report fraud on our website. Submitting a report through the Web is private too. Go to [www.ohanahealthplan.com](http://www.ohanahealthplan.com).

## MEMBER RIGHTS AND RESPONSIBILITIES

As an 'Ohana member, you have the right:

- To get information about the plan, its services, and its providers.
- To get information about your rights and responsibilities.
- 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 talk about the care you need particular to your 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 health care 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 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.
- To request to amend or correct your medical records.
- To have your records kept private.
- To make your health care wishes known by using advance directives.
- To have input in the plan's member rights.
- 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 health care services that are accessible, comparable in amount, duration and scope to those provided under Medicaid 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 appropriate services that are not denied or cut back just because of diagnosis, type of illness, or medical condition.
- 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 the member's PCP.
- To have all these rights apply to the person who you legally appoint to make decisions about your health care.
- 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 the member.
- 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 he or she would have if services were provided in-network.
- To receive services according to the appointment waiting time standards.
- To receive service in a culturally competent manner.
- To receive services in a coordinated manner.
- To have his or her privacy protected.
- Be included in care plan development.
- To have direct access to specialists (if he or she has a special health care need)
- Not have services arbitrarily denied or reduced in amount, duration or scope solely because of diagnosis, type of illness, or condition.
- To choose between institutional care and HCBS (if determined cost-neutral by the health plan).
- 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 the member by the health plan for which the DHS does not pay the health plan
  - Covered services provided to the member 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 the member would owe if the health plan provided the services directly
  - Only be responsible for cost-sharing as described by your plan

**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 of adopting the policy
2. To member before and during enrollment
3. To members within 90 days of adopting the policy with respect to any particular 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 health care.
- 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 help your PCP obtain 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 at **1-888-846-4262** (TTY/TDD: **1-877-247-6272**).

## WELLCARE NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

***Effective Date of this Privacy Notice: July 15, 2010***

We are required by law to protect the privacy of health information that may reveal your identity. We are also required by law to provide you with a copy of this Privacy Notice which describes not only our legal duties and health information privacy practices, but also the rights you have with respect to your health information.

**This Privacy Notice applies to the following WellCare entities:**

- WellCare of Florida, Inc.
- HealthEase of Florida, Inc.
- WellCare of New York, Inc.
- WellCare of Connecticut, Inc.
- WellCare of Louisiana, Inc.
- WellCare of Georgia, Inc.
- WellCare of Ohio, Inc.
- WellCare of Texas, Inc.
- WellCare Health Plans of New Jersey, Inc.
- Harmony Health Plan of Illinois, Inc.
- WellCare Prescription Insurance, Inc.
- WellCare Health Insurance of Arizona, Inc.
- WellCare Health Insurance of Illinois, Inc.
- WellCare Health Insurance of New York, Inc.
- WellCare Specialty Pharmacy, Inc.

We may change our privacy practices from time to time. If we make any material revisions to this Notice, we will provide you with a copy of the revised Notice which will specify the date on which such revised Notice becomes effective. The revised Notice will apply to all of your health information from and after the date of the Notice.

### **HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION**

WellCare requires its employees to follow its privacy and security policies and procedures to protect your health information in oral (for example, when discussing your health information with authorized individuals over the telephone or in person), written or electronic form.

**1. Treatment, Payment, and Business Operations.** *We may use your health information or share it with others to help treat your condition, coordinate payment for that treatment, and run our business operations. For example:*

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**Treatment.** We may disclose your health information to a health care provider that provides treatment to you. We may use your information to notify a physician who treats you of the prescription drugs you are taking.

**Payment.** We will use your health information to obtain premium payments, specialty pharmacy payments, or to fulfill our responsibility for coverage and the provision of benefits under a health plan, such as processing a physician claim for reimbursement for services provided to you.

**Health Care Operations.** We may also disclose your health information in connection with our health care operations. These include fraud and abuse detection and compliance programs, customer service and resolution of internal grievances.

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

**Your Authorization.** In addition to our use of your health information for treatment, payment or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You may also revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those as described in this Notice.

**Family Members, Relatives or Close Friends Involved In Your Care.** Unless you object, we may disclose your health information to your family members, relatives or close personal friends identified by you as being involved in your treatment or payment for your medical care. If you are not present to agree or object, we may exercise our professional judgment to determine whether the disclosure is in your best interest. If we decide to disclose your health information to your family member, relative or other individual identified by you, we will only disclose the health information that is relevant to your treatment or payment.

**Business Associates.** We may disclose your health information to a “business associate” that needs the information in order to perform a function or service for our business operations. Third party administrators, auditors, lawyers, and consultants are some examples of business associates.

**2. Public Need.** *We may use your health information, and share it with others, in order to comply with the law or to meet important public needs that are described below:*

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

- in the unfortunate event of your death, to a coroner or medical examiner, for example, to determine the cause of death;
- to funeral directors as necessary to carry out their duties; and
- in the unfortunate event of your death, to organizations that procure or store organs, eyes or other tissues so that these organizations may investigate whether donation or transplantation is possible under law.

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

## **YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION**

*We want you to know that you have the following rights to access and control your health information.*

**1. Right to Access Your Health Information.** You have the right to inspect and obtain a copy of your health information except for health information: (i) contained in psychotherapy notes; (ii) compiled in anticipation of, or for use in, a civil, criminal, or administrative proceeding; and (iii) with some exceptions, information subject to the Clinical Laboratory Improvements Amendments of 1988 (CLIA). If we use or maintain an electronic health record (EHR) for you, you have the right to obtain a copy of your EHR in electronic format, and you have the right to direct us to send a copy of your EHR to a third party you clearly designate.

If you would like to access your health information, please send your written request to the address listed on the last page of this Privacy Notice. We will ordinarily respond to your request within 30 days if the information is located in our facility, and within 60 days if it is located off-site at another facility. If we need additional time to respond, we will let you know as soon as possible. We may charge you a reasonable, cost-based fee to cover copy costs and postage. If you request a copy of your EHR, we will not charge you any more than our labor costs in producing the EHR to you.

We may not give you access to your health information if it: (1) is reasonably likely to endanger the life and physical safety of you or someone else; (2) refers to another person and your access is likely to cause harm to that person; or (3) a health care professional determines that your access as the representative of

another person is likely to cause harm to that person or any other person. If you are denied access for one of these reasons, you are entitled to a review by a health care professional, designated by us, who was not involved in the decision to deny access. If access is ultimately denied, you will be entitled to a written explanation of the reasons for the denial.

**2. Right to Amend Your Health Information.** If you believe we have health information about you that is incorrect or incomplete, you may request in writing an amendment to your health information. If we do not have your health information, we will give you the contact information of someone who does. You will receive a response within 60 days after we receive your request. If we did not create your health information or your health information is already accurate and complete, we can deny your request and notify you of our decision in writing. You can also submit a statement that you disagree with our decision, which we can rebut. You have the right to request that your original request, our denial, your statement of disagreement, and our rebuttal be included in future disclosures of your health information.

**3. Right to Receive an Accounting of Disclosures.** You have the right to receive an accounting of disclosures of your health information made by us and our business associates. You may request such information for the six-year period prior to the date of your request. Accounting of disclosures will not include disclosures: (i) for payment, treatment or health care operations; (ii) made to you or your personal representative; (iii) you authorized in writing (iv) made to family and friends involved in your care or payment for your care; (v) for research, public health or our business operations; (vi) made to federal officials for national security and intelligence activities and (vii) incident to a use or disclosure otherwise permitted or required by law.

If you would like to receive an accounting of disclosures, please write to the address listed on the last page of this Privacy Notice. If we do not have your health information, we will give you the contact information of someone who does. You will receive a response within 60 days after your request is received. You will receive one request annually free of charge, but we may charge you a reasonable, cost-based fee for additional requests within the same twelve-month period.

**4. Right to Request Additional Privacy Protections.** You have the right to request that we place additional restrictions on our use or disclosure of your health information. If we agree to do so, we will abide by our agreement except in an emergency situation. We do not need to agree to the restriction unless the information pertains solely to a health care item or service that you have paid for out of pocket and in full.

5. **Right to Request Confidential Communications.** You have the right to request that we communicate with you about your health information by alternative means or via alternative locations provided that you clearly state that the disclosure of your health information could endanger you. If you wish to receive confidential communications via alternative means or locations, please submit your written request to the address listed on the last page of this Privacy Notice and how or where you wish to receive communications.

6. **Right to Notice of Breach of Unencrypted Health Information.** Our policy is to encrypt our electronic files containing your health information so as to protect the information from those who should not have access to it. If, however, for some reason we experience a breach of your unencrypted health information, we will notify you of the breach. If we have more than ten people that we cannot reach because of outdated contact information, we will post a notification either on our Web site ([www.wellcare.com](http://www.wellcare.com)) or in a major media outlet in your area.

7. **Right To Obtain A Paper Copy Of This Notice** You have the right at any time to obtain a paper copy of this Privacy Notice, even if you receive this Privacy Notice electronically. Please send your written request to the address listed on the last page of this Privacy Notice or visit our Web site at [www.wellcare.com](http://www.wellcare.com).

## MISCELLANEOUS

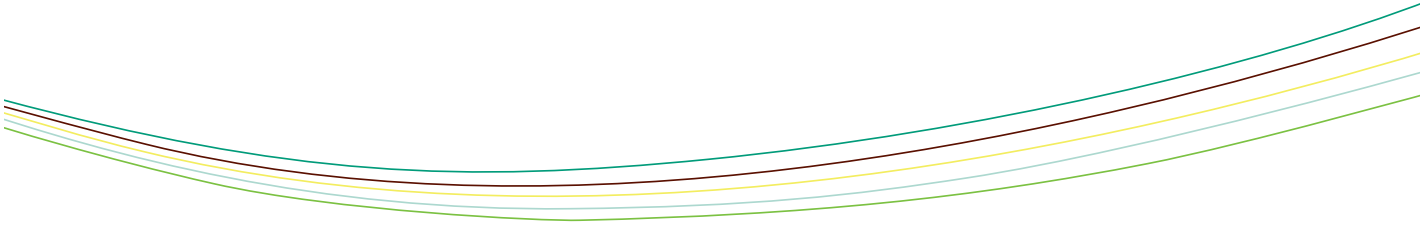
1. **Contact Information.** If you have any questions about this Privacy Notice, you may contact the Privacy Officer at 1-866-530-9491, call the toll-free number listed on the back of your membership card, visit [www.wellcare.com](http://www.wellcare.com), or write to us at:

WellCare Health Plans, Inc.  
Attention: Privacy Officer  
P.O. Box 31386  
Tampa, FL 33631-3386

2. **Complaints.** If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information above. You also may submit a written complaint to the U.S. Department of Health and Human Services. If you choose to file a complaint, we will not retaliate in any way.

3. **Additional Rights.** Special privacy protections may apply to certain information involving HIV/AIDS, mental health, alcohol and drug abuse, sexually transmitted diseases, and reproductive health. Please see the attached chart entitled ***Information Regarding More Protective State Privacy Laws for WellCare Health Plans*** for additional information. If the law in the state where you reside affords you greater rights than described in this Notice, we will comply with these laws.





1-888-846-4262 (TTY/TDD: 1-877-247-6272)  
[www.ohanahealthplan.com](http://www.ohanahealthplan.com)