



MEMBER SERVICES

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Overview

The Plan will make information available to members on the role of the PCP, how to obtain care, what to do in an emergency or urgent medical situation as well as their rights and responsibilities. The Plan will convey this information through various methods including an Evidence of Coverage booklet.

Evidence of Coverage Booklet

All newly enrolled members will receive an Evidence of Coverage booklet within 10 calendar days of receiving the notice of enrollment from the Plan. The Plan will mail all enrolled members an Evidence of Coverage booklet annually thereafter.

Enrollment

The Plan accepts members without consideration of the applicant's health condition, gender, race, religious belief, national origin or handicap.

Upon enrollment in the Plan, members are provided with the following:

- Terms and conditions of enrollment;
- Description of covered services in-network and out-of-network (if applicable);
- Information about PCPs, such as location, telephone number and office hours;
- Information regarding "Out-of-Network" emergency services;
- Grievance and disenrollment procedures; and
- Brochures describing certain benefits not traditionally covered by Medicare and other value-added items or services, if applicable.

Member Identification Cards

Member identification cards are intended to identify Plan members, the type of plan they have and facilitate their interactions with physicians and other health care providers. Information found on the member identification card may include the member's name,



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identification number, plan type, Primary Care Physician's (PCP's) name and telephone number, co-payment information, health plan contact information and claims filing address. Possession of the member identification card does not guarantee eligibility or coverage. The physician or provider is responsible for ascertaining the current eligibility of the cardholder.

Eligibility Verification

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

Providers may do one of the following to verify eligibility:

- Access the 'Ohana Web site at ohanahealthplan.com. (Contact your Provider Relations representative to schedule a Web site in-service.)
- Access the Plan's Interactive Voice Response (IVR) system. You will need your Provider ID number to access member eligibility.
- Contact the Customer Service department.

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

Member Rights and Responsibilities

Plan members, adults and children have specific Rights and Responsibilities. These are included in the Evidence of Coverage booklet.

Plan members have the right:

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- To be treated with fairness and respect.
- To privacy of their medical records and personal health information.
- To see Plan providers, get covered services and get their prescriptions filled within a reasonable period of time.
- To know their treatment choices and participate in decisions about their health care.
- To use advance directives (such as a living will or a power of attorney).
- To make complaints.
- To get information about their health care coverage and costs.
- To get information about the Plan, Plan providers, their drug coverage and costs.

Members also have certain responsibilities. These include the responsibility:

- To get familiar with their coverage and the rules they must follow to get care as a member.
- To give their doctor and other providers the information they need to care for them, and to follow the treatment plans and instructions that they and their doctors agree upon.
- To ask their doctors and other providers if they have any questions and to explain their treatment in a way they understand.
- To act in a way that supports the care given to other patients and helps the smooth running of their doctor's office, hospitals and other offices.
- To pay their plan premiums and any co-payments or coinsurance they owe for the covered services they get. They must also meet

their other financial responsibilities as described



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in the Evidence of Coverage booklet.

- To let the Plan know if they have any questions, concerns, problems or suggestions. If they do, please call the Member Services phone number listed in the Evidence of Coverage booklet.

Assignment of Primary Care Physician

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

PPO members are not required to choose a PCP from the Plan's network, although they may elect to do so.

Changing Primary Care Physicians

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

Women's Health Specialists

PCPs may also provide routine and preventive health care services that are specific to female members. If a female member selects a PCP who does not provide these services, she has the right to direct in-network access to a women's health specialist for covered services related to this type of routine and preventive care.

Hearing- Impaired, Interpreter and Sign Language Services

Hearing-impaired, interpreter and sign language services are available to Plan members through Customer Service. PCPs should coordinate these services for Plan members and contact Customer Service if assistance is needed. Please refer to your state-specific **Quick Reference Guide** for the Customer Service telephone number.

¹Ohana Health Plan
A plan offered by WellCare Health Insurance of Arizona, Inc.