‘ohana health plan™

Hawaii
Member Handbook
QUEST (Medicaid)

Beyond Healthcare. A Better You.

OhanaHealthPlan.com

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ʻOhana Health Plan...

BEYOND HEALTHCARE.
A BETTER YOU.

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

Aloha! Welcome to ‘Ohana Health Plan.

‘Ohana is a managed care plan for QUEST (Medicaid) members. Many people now get their health benefits through managed care. Managed care plans like ‘Ohana are contracted by the Department of Human Services to help provide quality, cost-effective healthcare. We work with providers, specialists, hospitals, labs and other healthcare facilities that are a part of our network to provide the benefits offered by Medicaid and to coordinate your healthcare needs. As a member, you may choose a primary care provider (PCP). Your PCP will be your personal provider. They will treat you for most of your healthcare needs and will work with you to direct your healthcare. (For more information on PCPs, see Page 23).

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

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

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

We wish you good health!

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We’re Here to Help

We're Here to Help

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

Help from ʻOhana Customer Service

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

Call with questions about:

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

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

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

You can also contact Customer Service by writing to:
ʻOhana Customer Service
820 Mililani Street
Suite 200
Honolulu, HI 96813

@OhanaHealthPlan
facebook.com/OhanaHealthPlan

We Protect Your Privacy!

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

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

Other ʻOhana Offices

ʻOhana Health Plan – Big Island Office
88 Kanoelehua Ave
Suite A105
Hilo, HI 96720

Our Service Area

'Ohana serves the following areas:

- Kauai
- Molokai
- Lanai
- Oahu
- Maui
- Hawaii

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

Sometimes, you may want to call a nurse for urgent medical questions. You can call our 24-hour Nurse Advice Line any time, even after business hours, on holidays, or on weekends. A nurse will try to answer your questions and help you when you are not feeling well. Please see the Nurse Advice Line section later in this handbook on page 25.

Important Phone Numbers

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

Sign In to Your Secure Member Portal on our Website

When you want general information, try checking our website. Visit ohanahealthplan.com to learn about:

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

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

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

QUEST (Medicaid) Ombudsman Program

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

- Making sure you have access to care.
- Promoting quality of your care.
- Making sure members like you are satisfied with QUEST (Medicaid) services.

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

Island	Phone Number
Oahu	**1-808-746-3324**
Hawaii	**1-888-488-7988**
Maui and Lanai	**1-888-488-7988**
Molokai	**1-888-488-7988**
Kauai	**1-888-488-7988**
Email: **hiombudsman@koanrisksolutions.com**	**TTY: 711**
Oahu fax: **1-808-356-1645**	

The ʻOhana Glossary

WORDS/PHRASES
Abuse: Any practices that are inconsistent with sound fiscal, business, or medical practice and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations (including the terms of the RFP, contracts and requirements of state and federal regulations) for healthcare in the managed care setting. Incidents or practices of providers that are inconsistent with professionally recognized standards for healthcare. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.
Acute Care: Short-term medical treatment provided under the direction of a physician, usually in an acute care hospital, for members having an acute illness or injury.
Advance Directive: A written instruction, such as a living will or durable power of attorney for healthcare, recognized under state law relating to provision of healthcare when the individual is incapacitated.
Appeal: A review by the Health Plan and State Administrative Appeal of an adverse benefit determination.
“At-Risk” Services: Some members living at home might need at-risk services to prevent them from worsening.
Authorized Representative: An individual or organization designated by the member, in writing, with the designee’s signature or by legal documentation of authority to act on behalf of a member, in compliance with federal and state law regulations. Designation of an authorized representative may be requested at time of application or at other times as required and will be accepted through the same modalities as applications for medical assistance.
Benefits: Those health services that the Member is entitled to under the QI program and that the Health Plan arranges to provide to its Members.
Community Care Services (CCS): A behavioral health program administered by DHS. CCS provides eligible adult Members specialized behavioral health services to severe mental illness (SMI) and severe and persistent mental illness (SPMI).
Copayment (Copay): The amount that a Member shall pay, usually a fixed amount of the cost of a service.

WORDS/PHRASES

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

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

Durable Medical Equipment (DME): Medical equipment that is ordered by a doctor for use in the home. These items shall be reusable, such as walkers, wheelchairs, or hospital beds. DME is paid for under both Medicare Part B and Part A for home health services.

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

Emergency Medical Condition: The sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms and substance abuse) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of emergency services or immediate medical attention might result in:

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

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

Emergency Room Services: Emergency services provided in an emergency room.

WORDS/PHRASES

Emergency Services: Covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition that is found to exist using a prudent layperson standard.

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

Excluded Services: Healthcare services that health plan does not pay for or cover.

EPSDT (Early and Periodic Screening, Diagnostic and Treatment) Comprehensive Visits: EPSDT services aim to identify physical or mental defects in individuals and provide healthcare, treatment, and other measures to correct or ameliorate any defects and chronic condition discovered in accordance with Section 1905r of the Social Security Act. EPSDT includes services to:

a. Seek out individuals and their families and inform them of the benefits of prevention and the health services available;

b. Help the individual or family use health resources, including their own talents, effectively, and efficiently; and

c. Ensure the problems identified are diagnosed and treated early, before they become more complex and their treatment more costly.

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

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

Grievance: An expression of dissatisfaction from a Member, Member’s representative, or provider on behalf of a Member about any matter other than an adverse benefit determination.

Health Insurance: A contract that requires the health insurer to pay some or all of healthcare costs in exchange for a premium.

WORDS/PHRASES

Habilitation Devices: Devices that support the provision of Habilitation Services in inpatient and/or outpatient settings. Habilitation devices include but are not limited to:

- **a.** Mobility devices, such as wheelchairs, motorized scooters, walkers, crutches, canes, prosthetic devices, orthotic braces, and other orthotic devices.
- **b.** Devices that aid hearing loss, including hearing aids, cochlear implants (pediatric and adult), and hearing assistive technology.
- **c.** Devices that aid speech include DME, and augmentative and alternative communication devices, such as voice amplification systems.
- **d.** Prosthetic eyeglasses and prosthetic contact lenses for the management of a congenital anomaly of the eye.
- **e.** Dental devices (not for cosmetic purposes).

Habilitative / Habilitation Services: Healthcare services that help to keep, learn, or improve skills and functioning for daily living. An example is therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

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

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

Home Healthcare: Limited part-time or intermittent skills nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, DME (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.

Hospice Services: Services to provide comfort and support for Members in the last stages of a terminal illness and their families.

WORDS/PHRASES

Hospital: Any licensed acute care facility in the service area to which a Member is admitted to receive inpatient services pursuant to arrangements made by a physician. Acute care hospitals may additionally be designated as CAHs, as defined by the Medicare Rural Hospital Flexibility Program.

Hospital Outpatient Care: Care in a hospital that usually does not require an overnight stay.

Hospitalization: Care in a hospital that requires admission as an inpatient for an overnight stay. An overnight stay for observation could be outpatient care.

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 Hawaii.

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

Long-Term Services and Supports (LTSS): Services provided to a Member in an inpatient medical facility receiving NF LOC or to a resident of a NF LOC. These facilities include assisted living facilities, expanded adult care homes, community care foster family homes, nursing facilities, and sub-acute units.

Managed Care: A comprehensive approach to the provision of healthcare that combines clinical services and administrative procedures within an integrated, coordinated system to provide timely access to primary care and other necessary services in a cost effective manner.

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

Medically Necessary: Procedures and services, as determined by DHS, which are considered to be necessary and for which payment will be made. Medically-necessary health interventions (services, procedures, drugs, supplies, and equipment) shall be used for a medical condition. There shall be sufficient evidence to draw conclusions about the intervention's effects on health outcomes. The evidence shall demonstrate that the intervention can be expected to produce its intended effects on health outcomes. The intervention's beneficial effects on health outcomes shall outweigh its expected harmful effects. The intervention shall be the most cost-effective method available to address the medical condition. Sufficient evidence is provided when evidence is sufficient to draw conclusions, if it is peer-reviewed, is well-controlled, directly or indirectly relates the intervention to health outcomes, and is reproducible both within and outside of research settings.

WORDS/PHRASES

Member: An individual who has been designated by DHS to receive medical services through the QI program and is currently enrolled in a QI Health Plan.

Network: A group of doctors, hospitals, pharmacies, and other healthcare experts hired by a health plan to take care of its Members.

Non-Participating Provider: A provider who does not have a contract with any health insurers or plans to provide services to Members.

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

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

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

Participating Provider: A provider who has a contract with health plans to provide services.

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

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

Plan: A benefit provided by employers, unions, or other group sponsors to pay for healthcare services.

Post-Stabilization Services: Covered services related to an emergency medical condition that are provided after a Member is stabilized in order to maintain the stabilized condition or to improve or resolve the Member's condition.

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

Premium: The cost of insurance coverage.

WORDS/PHRASES

Prescription Drug Coverage: Health plan that helps pay for prescription drugs and medications.

Prescription Drug: Drugs and medications that, by law, require a prescription.

Primary Care Provider (PCP): A practitioner selected by the Member to manage the Member's utilization of health care services who is licensed in Hawaii and is:

- **a.** A physician, either an MD or a DO, and shall generally be a family practitioner, general practitioner, general internist, pediatrician or obstetrician-gynecologist (for women, especially pregnant women) or geriatrician;
- **b.** An APRN-Rx. PCPs have the responsibility for supervising, coordinating, and providing initial and primary care to enrolled individuals and for initiating referrals and maintaining the continuity of their care; or
- **c.** A physician's assistant recognized by the State Board of Medical Examiners as a licensed physician assistant.

Prior Authorization: A decision by a Health Plan that a healthcare service, treatment plan, prescription drug, or DME is medically necessary. Sometimes called prior authorization, prior approval, or precertification. A Health Plan may require preauthorization for certain services prior to Members receiving them, except in an emergency. Preauthorization does not guarantee the Health Plan will cover the cost.

Providers: Any licensed or certified person or public or private institution, agency, or business concern authorized by DHS to provide healthcare, services, or supplies to individuals receiving medical assistance.

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

QUEST (Medicaid): The managed care program that provides healthcare benefits, including LTSS, to individuals, families, and children; the program serves both non-ABD individuals and ABD individuals, with household income up to a specified FPL. This is the demonstration project developed by DHS.

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

WORDS/PHRASES

Rehabilitative/Rehabilitation Services: Healthcare services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Rehabilitation Devices: Devices that support the provision of rehabilitation services in inpatient and/or outpatient settings. Rehabilitation devices include but are not limited to:

- **a.** Mobility devices, such as wheelchairs, motorized scooters, walkers, crutches, canes, prosthetic devices, orthotic braces, and other orthotic devices.
- **b.** Devices that aid hearing loss, balance or tinnitus disorders, including hearing aids, aural rehabilitation with cochlear implants for both pediatric and adult, and hearing assistive technology.
- **c.** Devices that aid speech include DME, speech-generating equipment, and augmentative and alternative communication devices, such as voice amplification systems.
- **d.** Cognitive aids to assist with memory, attention, and other challenges with cognition.
- **e.** Prosthetic eyeglasses and prosthetic contact lenses for the management of trauma to the eye or ophthalmologic disease.
- **f.** Dental devices, excluding devices for cosmetic purposes.

Skilled Nursing Care: A LOC that includes services that can only be performed safely and correctly by a licensed nurse (either a RN, a LPN, or APRN).

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of healthcare.

Treatment: The care you get from doctors and facilities.

Urgent Care: The diagnosis and treatment of medical conditions which are serious or acute but pose no immediate threat to life or health but which require medical attention within 24 hours.

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

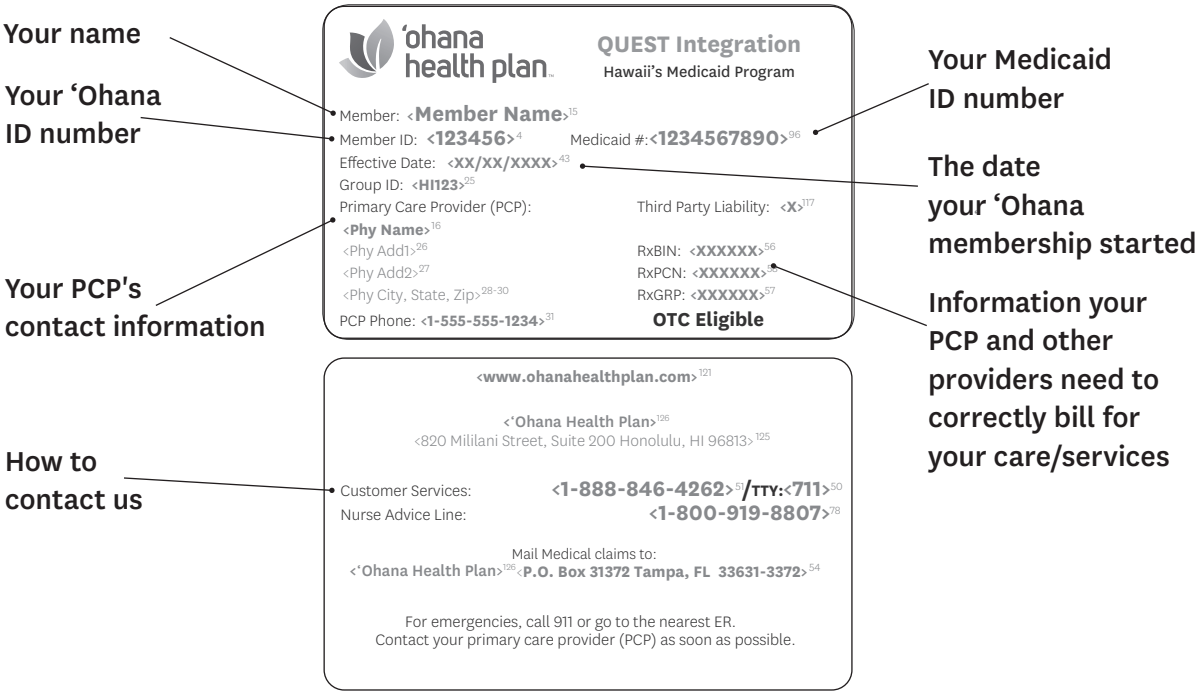
Getting Started With Us

How to Get The Most From Your Plan

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

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

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



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

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

Call ʻOhana Customer Service as soon as possible if:

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

2 Using Your Medicare and QUEST (Medicaid) Benefits

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

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

Have Questions?

Our Customer Service agents are knowledgeable with Medicare and Medicaid products. We will help share how these two plans work together. Call us toll-free at 1-888-846-4262 (TTY: 711).

3 Choosing Your PCP

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

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

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

Do you have Original Medicare or a Medicare Advantage Plan? If so, you do not need to pick a PCP for QUEST (Medicaid).

4 Changing Your PCP

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

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

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

For a list of our PCPs:

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

You can learn more about your provider(s) by calling Customer Service. A Customer Service agent can tell you about a provider's schooling or residency, qualifications, or whether they are taking new patients. You can also find this information in your Provider Directory.

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

5 Get to Know Your Primary Care Provider (PCP)

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

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

Our PCPs are trained in different specialties. They include:

- Family and internal medicine.
- General practice.
- Geriatrics.
- Pediatrics.
- Obstetrics / Gynecology (OB/GYN).
- Advanced practiced registered nurse services.

A specialist can be your PCP if:

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

AND

- The specialist agrees in writing to be your PCP.

6 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 pick a provider in our network. You can also see a list of providers at **ohanahealthplan.com**.

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

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

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

7 Get to Know Your 24-Hour Nurse Advice Line

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

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

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

- Go to the hospital.
- Go to your PCP or an urgent care center.
- Care for yourself at home.

Call when you need help with problems like:

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

A nurse is there to help. Call the 24-Hour Nurse Advice Line before you go to the hospital, especially when it may not be an emergency.

8 In an Emergency

For a MEDICAL EMERGENCY, go to the hospital or call **911**. Please read the *Emergency Services* section of this book on page 78. It tells you how you can get care. It also gives examples of emergencies.

9 Call Us / Tell Us

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

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

Customer Service
820 Mililani Street
Suite 200
Honolulu, HI 96813

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

- You change your name.
- You move or change your phone number or address (mailing or residential).
- Your family size changes — for example, if you get married or divorced, have a baby, or adopt a child.

- Your health status changes — for example, if you become pregnant or are permanently disabled.
- You start a new job or your income changes.
- You get health insurance from another company.
- You are institutionalized — for example, in a state mental hospital, Hawaii Youth Correctional Facility, or prison.

10 ʻOhana Members Have Certain Rights and Responsibilities

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

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

Your Health Plan

Access to Covered Services

Making and Getting to Your Medical Appointments

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

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

Provider	Urban	Rural
PCPs, specialists, OB/GYN, adult day care / adult day health, hospitals, emergency services facilities, mental health providers, LTSS providers	30-minute driving time to get to your appointment	60-minute driving time to get to your appointment
Pharmacies	15-minute driving time to get to a network pharmacy	60-minute driving time to get to a network pharmacy
24-hour pharmacy	60-minute driving time to get to a network pharmacy	N/A

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

Type of Appointment	Type of Care	Appointment Time
Medical	Emergency	Right away (both in and out of our service area), 24 hours a day, seven days a week. Prior authorization is not required for emergency services. Emergency services outside of the United States are not covered (except for U.S. Territories, such as Guam and American Samoa).
	Urgent and PCP pediatric sick visits	Within 24 hours (one day).
	PCP adult sick visits	Within 72 hours (three days).
	Routine / wellness	Within 21 days (three weeks).
	Specialist and non-emergency hospital care	Within four weeks (one month) or of sufficient timeliness to meet medical necessity.
	Follow-up care after a hospital stay	As needed.

Type of Appointment	Type of Care	Appointment Time
Mental Health and Substance Use	Emergency	Right away (both in and out of our service area), 24 hours a day, seven days a week. Prior authorization is not required for emergency services. Emergency services outside of the United States are not covered (except for U.S. Territories, such as Guam and American Samoa).
	Routine / wellness	Within 21 days (three weeks).

Your Financial Responsibilities

Cost Sharing

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

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

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

You may be billed directly by the rendering provider for any Non-Covered Services and for Covered Services exceeding any established limits, as applicable. Please see the Non-Covered and Covered Services section of your handbook for additional details.

Covered Services

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

Behavioral Health Services	Coverage and Limits
Inpatient and outpatient mental health and substance use	**Covered services include all medically necessary behavioral health services for QUEST (Medicaid) members:** • 24-hours-a-day care for acute psychiatric illnesses, including: – Ancillary services. – Room and board in an acute hospital. – Nursing care. – Medical supplies and equipment. – Medication management. – Diagnostic services. – Physician services. – Other practitioner services, as needed. – Other medically necessary services. • Ambulatory services, including 24/7 crisis services. • Acute day hospital / partial hospitalization, including: – Medication management. – Prescribed drugs. – Medical supplies. – Diagnostic Tests. – Therapeutic services, including individual, family, and group therapy and aftercare. – Other medically necessary services.

Behavioral Health Services	Coverage and Limits
Inpatient and outpatient mental health and substance use (continued)	• Methadone treatment services, which include the provision of methadone or a suitable alternative (for example, LAAM), as well as outpatient counseling services. • Prescribed drugs including medication management and patient counseling. • Diagnostic / laboratory services, including: – Psychological testing. – Screening for drug and alcohol problems. – Other medically necessary diagnostic services. • Psychiatric or psychological evaluation. • Physician services. • Rehabilitation services. • Occupational therapy. • Other medically necessary therapeutic services. *May require prior authorization. See details on page* 76.
Additional behavioral health services	**For members who have a Serious and Persistent Mental Illness (SPMI) and meet the functional eligibility criteria, additional benefits may be available through the Community Care Services (CCS) Program, including:** • Health coordination. • Psychosocial rehabilitation. • Clubhouse. • Peer support. • Supported employment. • Partial or intensive outpatient hospitalization. *Prior authorization required. See details on page* 76.

Medical Health Services	Coverage and Limits
Acute inpatient hospital care	**Includes the cost of room and board for inpatient stays for:** • Nursing care. • Medical supplies. • Equipment. • Drugs. • Diagnostic services. • Physical and occupational therapy. • Audiology. • Speech-language pathology services. • All other medically necessary services. *May require prior authorization. See details on page* 76.
Adult day care	**Adult day care refers to regular supportive care provided to four or more adult participants who have disabilities. Services include:** • Observation and supervision by center staff. • Coordination of behavioral, medical, and social plans and implementation of the instructions as listed in the participant's care plan. • Therapeutic, social, educational, recreational, and other activities. *Prior authorization required. See details on page* 76.

Medical Health Services	Coverage and Limits
Adult day health	**Adult day health services are organized day programs for therapeutic, social, and health services provided to adults with physical or mental impairments (requires nursing oversight or care). This includes:** • Emergency care. • Dietetic services. • Occupational therapy. • Physical therapy. • Physician services. • Pharmaceutical services. • Psychiatric or psychological services. • Recreational and social activities. • Social services. • Speech-language therapy. • Transportation services. *Prior authorization required. See details on page* 76.
Assisted living services	**Assisted living services include:** • Personal care. • Supportive care services (homemaker, chore, attendant services, and meal preparation). The health plan is not responsible for payment of room and board. *Prior authorization required. See details on page* 76.

Medical Health Services	Coverage and Limits
At-risk services	Some ʻOhana members may not need the same kind of care that they would get in a nursing home, but could still need certain additional services. If not getting these services would result in the member ending up in a nursing home, they are considered "at-risk." Member must live at home and need to meet the "at-risk" criteria. An assessment is completed by your provider or Health Coordinator. **At-risk services potentially may include:** • Home-delivered meals. • Personal Emergency Response System (PERS). • Personal assistance level I and II. • Adult day care. • Adult day health. • Private duty nursing. Criteria for each of these services and MQD approval must be met to qualify for these services. *Prior authorization required. See details on page* 76.
Cognitive rehabilitation services	**Services provided to individuals with cognitive impairments that are meant to assess and treat:** • Communication skills. • Cognitive and behavioral abilities. • Cognitive skills related to performing ADLs. Treatment may last up to one year if the member is making progress. Covered services include assessments completed at regular times (determined by the provider and according to the member's needs) *Prior authorization required. See details on page* 76.

Medical Health Services	Coverage and Limits
Community Care Foster Family Home (CCFFH) services	**Covered services include:** • Personal care. • Homemaker services. • Companion services. • Day programming. • Supportive services. • Attendant care. • Local transportation. • Medication oversight (to the extent permitted under state law). All services must be provided in a certified private home by a principal care provider who lives in the home. *Prior authorization required. See details on page* 76.
Community Care Management Agency (CCMA)	Covered for members living in community care, foster family homes, and other community settings, as required. *Prior authorization required. See details on page* 76.

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

Medical Health Services	Coverage and Limits
Community Integration Services (CIS) (continued)	• Other housing and tenancy support services, such as: – Job skills training / employment activities. – Peer supports. – Non-medical transportation. – Support groups. – Caregiver / family support. – Outreach and in-reach services. – Health management. – Counseling and therapies. – Services assessments. – Service plan development. – Independent living skills / financial literacy. – Equipment, technology, and other modifications. – Home management. – Other supplemental services as needed. *May require prior authorization. See details on page* 76.

Medical Health Services	Coverage and Limits
Counseling and training	**Counseling and training activities include:** • Member care training for members. • Family and caregiver training regarding the nature of the disease and the disease process. • Methods of transmission and infection control measures. • Biological, psychological care, and special treatment needs / regimens. • Employer training for consumer-directed services. • Use of equipment specified in the service plan. • Employer skills updates as necessary to safely maintain the individual at home. • Crisis intervention. • Supportive counseling. • Family therapy. • Suicide risk assessments and intervention. • Death and dying counseling. • Anticipatory grief counseling. • Substance use counseling. • Nutritional assessment and counseling on coping skills to deal with the stress caused by deteriorating functional, medical, or mental status. **Counseling and training is a service provided to:** • Members. • Families / caregivers on behalf of the member. • Professional and paraprofessional caregivers on behalf of the member. *Prior authorization required. See details on page* 76.

Medical Health Services	Coverage and Limits
Dental services to treat medical conditions	**Health plan emergency covered services include:** • Dental services performed by a dentist or physician that are needed due to a medical emergency where the services provided are primarily medical. • Providing sedation services associated with dental treatment, when performed in an acute care setting, by a physician anesthesiologist. • Dental services in relation to oral or facial trauma, oral pathology (including but not limited to infections of oral origin and cyst and tumor management), and craniofacial reconstructive surgery, performed on an inpatient basis in an acute care hospital setting. *May require prior authorization. See details on page* 76. **All other dental services for adults and children are coordinated through Community Case Management Corp. (CCMC) CCMC helps members:** • Find a dentist. • Explain the covered dental benefits. *See "Services Covered by Other Agencies" on page* 62.

Medical Health Services	Coverage and Limits
Dialysis	**Covered services and medical supplies include, but are not limited to:** • Services. • Equipment. • Supplies. • Diagnostic testing. • Drugs (medically necessary). Services may be provided as hospital inpatient, hospital outpatient, in a non-hospital renal dialysis facility, or in the members' home.
Durable medical equipment and medical supplies	**Covered services and medical supplies include, but are not limited to:** • Oxygen tanks and concentrators. • Ventilators. • Wheelchairs. • Crutches and canes. • Eyeglasses. • Pacemakers. • Hearing aids. • Incontinence supplies. • Orthotic devices. • Prosthetic devices. • Medical supplies such as surgical dressings and ostomy supplies. • Foot appliances (orthoses, prostheses). • Orthopedic shoes and casts. • Orthodigital prostheses and casts. • Other medically necessary durable medical equipment. *May require prior authorization. See details on page* 76.
Early and Periodic Screening Diagnostic and Treatment (EPSDT)	Please see the *Well-Child Care and EPSDT (Early and Periodic Screening, Diagnostic and Treatment) Services* section on page 82 for details on child health checkups.

Medical Health Services	Coverage and Limits
Emergency services	Covered for medically necessary services. Includes any screening examination services to find out whether an emergency medical condition exists. *Prior authorization is not required.*
Environmental accessibility adaptations	**Covered services include:** • Installing ramps and grab bars. • Widening doorways. • Modifying bathroom facilities. • Installing specialized electric and plumbing systems (must be necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual). • Installing window air conditioning when it is needed for the health and safety of the member. **Excluded are changes or improvements to the home that do not have a direct medical or remedial benefit to the member, such as:** • Carpeting. • Roof repair. • Central air conditioning. • Changes that add square footage to the home. All services shall comply with state or local building codes. *Prior authorization required. See details on page* 76.

Medical Health Services	Coverage and Limits
Family planning services	**Covers:** • Education and counseling. • Emergency contraception. • Follow-up visits. • Brief and comprehensive visits. • Pregnancy testing. • Contraceptive supplies and follow-up care. • Diagnosis and treatment of sexually transmitted infections (STIs). • Infertility assessment. • Sterilization procedures. *Family planning does not require a referral from your PCP. Certain procedures may require prior authorization. See details on page 76.* *'Ohana offers family planning services within our network. However, members have freedom of choice. That means you can get these services from providers who are not in our network.*
Fluoride varnish	Topical fluoride varnish for children 1 to 6 years old only if they did not receive a topical fluoride treatment in the previous six months.

Medical Health Services	Coverage and Limits
Habilitative services and devices	**When medically necessary, covered services and devices include:** • Audiology services. • Occupational therapy. • Physical therapy. • Speech / language therapy. • Vision services. **Examples may include:** • Augmentative communication devices. • Reading devices. • Visual aids. These are excluded when used specifically for activities at school when medical necessity has not been established. Habilitative services do not include coverage for routine vision services. *May require prior authorization – see details on page* 76.
Health education and counseling	**Covered services include:** • Substance use, including alcohol. • Diet and exercise. • Injury prevention. • Sexual behavior. • Dental health. • Family violence. • Depression. • Results and implications of screenings listed above. *May require prior authorization. See details on page* 76.

Medical Health Services	Coverage and Limits
Hearing	**Hearing services include:** • Screening. • Diagnostic. • Corrective services, equipment, and/or supplies. **For adults 21 years and older:** • Fitting. • Orientation. • Hearing aid check (once every three years). **For children under age 21:** • Fitting. • Orientation. • Hearing aid check (two per three years). *Prior authorization is required for all hearing aid devices.*
Home health services	**Some home health services included are:** • Skilled nursing. • Home health aides. • Medical supplies and durable medical equipment. • Physical and occupational therapy. • Rehabilitation services. • Audiology and speech / language pathology. *May require prior authorization. See details on page* 76.

Medical Health Services	Coverage and Limits
Home maintenance	**Home maintenance services are those services not included as part of personal assistance and include:** • Heavy-duty cleaning to bring a home up to acceptable standards of cleanliness at the start of service to a member. • Minor repairs to essential appliances (limited to stoves, refrigerators, and water heaters). • Fumigation or extermination services. *Prior authorization required. See details on page* 76.
Home-delivered meals	Includes nutritious meals delivered to where a person lives. Cannot be delivered to residential or institutional settings. No more than two meals per day. *Prior authorization and level of care requirements required. See details on page 76.*
Hospice services	Provides care to terminally ill patients who have a life expectancy of six or fewer months as determined by their provider. Medicaid services provided to members who get Medicare hospice services that are the same as Medicare hospice benefits are not covered. Examples include personal care and homemaker services. This is covered only when the service need is not related to the hospice diagnosis. Children under the age of 21 can receive treatment to manage or cure their disease while concurrently receiving hospice services. *May require prior authorization. See details on page* 76.

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

Medical Health Services	Coverage and Limits
Long-term care – institutional services	Based on member's enrollment category as determined by the Department of Human Services (DHS). *Prior authorization required. See details on page 76.*
Medication Assisted Treatment (MAT)	Includes the provision of methadone or buprenorphine products and related outpatient counseling services for Opioid Use Disorder.
Maternity services	**Covers:** • Prenatal care. • Radiology, laboratory, and other diagnostic tests. • Treatment of missed, threatened, and incomplete abortions. • Delivery of the infant. • Postpartum care. • Prenatal vitamins. • Lactation counseling (for six months). • Breast pump (rental or purchased for six months). • Inpatient hospital services, physician services, other practitioner services, and outpatient services that impact pregnancy outcomes. • Four-day stay after cesarean delivery. • Two-day stay after vaginal delivery. • Screening, diagnosis, and treatment for pregnancy-related conditions, to include Screening, Brief Intervention, and Referral Treatment (SBIRT); screening for maternal depression; and access to necessary behavioral and substance use treatment or supports. • Educational classes on childbirth, breastfeeding, and infant care. • Counseling on healthy behaviors, to include prevention and harm reduction.

Medical Health Services	Coverage and Limits
Moving assistance	**Help moving is offered when the Health Coordinator finds that a member needs to move to a new home to keep health from getting worse. For Long Term Services and Support members, this includes:** • Unsafe home due to deterioration. • The individual must use a wheelchair but lives in a building with no elevator. • Multistory building with no elevator or where the member lives above the first floor. • Home unable to support the member's additional needs for equipment. • Member is evicted from their current living environment. • The member is no longer able to afford the home because of a rent increase. *Moving expenses include packing and moving of belongings.* *Prior authorization required. See details on page* 76.
Nursing facility services – both intermediate and skilled nursing	**Covered for members who need 24-hour-a-day help with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). These members need regular, long-term care from licensed nurses and paramedical personnel. Long-term services require MQD approval. Care is provided in a nursing facility that includes:** • Independent and group activities. • Meals and snacks. • Housekeeping and laundry services. • Nursing and social work services. • Nutritional monitoring and counseling. • Pharmaceutical services and rehabilitative services. *May require prior authorization – see details on page* 76.

Medical Health Services	Coverage and Limits
Other practitioner services	**Covered services include but are not limited to:** • Certified nurse midwife services. • Licensed advanced practice registered nurse services (including family, pediatric, geriatric, and psychiatric health specialists). • Paraprofessionals including peer support specialists. • Other medically necessary practitioner services provided by a licensed or certified healthcare provider to include behavioral health providers such as psychologists, marriage and family therapists, mental health counselors, and CSASs when medical necessity is established.
Out-of-state and off-island coverage	**We provide any medically necessary covered services that are prearranged when not available on your island or in Hawaii. This includes:** • Referrals to an out-of-state or off-island specialist or facility. • Transportation to and from the referral destination. • Lodging and meals. • An adult attendant that the member chooses (if medically necessary and authorized). *May require prior authorization – see details on page* 76.
Outpatient hospital care	**This service includes 24/7 care for:** • Emergency services. • Ambulatory center services. • Urgent care services. • Medical supplies. • Equipment and drugs. • Diagnostic services. • Therapeutic services (including chemotherapy and radiation therapy). • Other medically necessary services. *May require prior authorization – see details on page* 76.

Medical Health Services	Coverage and Limits
Outpatient hospital procedures	**Covered services include:** • Sleep laboratory services. • Surgeries performed in a free-standing ambulatory surgery center (ASC) and in a hospital ASC. *May require prior authorization – see details on page 76.*
Personal assistance services – level 1	**May be covered when authorized by the Health Coordinator for members who need help with key daily activities to prevent a decline in health status and keep them in their home. Services may include:** • Meal preparation. • Laundry. • Shopping. • Errands. • Light housekeeping tasks. *Prior authorization required. See details on page 76.*

Medical Health Services	Coverage and Limits
Personal assistance services – level 2	**Covered for those who need help with daily activities and keeping up their health. This level of service is to be provided by a home health aide (HHA), personal care aide (PCA), certified nurse aide (CNA) or nurse aide (NA) with applicable skills. Some activities include:** • Personal hygiene and grooming, including bathing, skin care, oral hygiene, hair care, and dressing. • Help with bowel and bladder care. • Help with mobility. • Help with transfers. • Help with medications. • Help with routine or maintenance healthcare services by a personal care provider. • Help with feeding, nutrition, meal preparation, and other dietary activities. • Help with exercise, positioning, and range of motion. • Taking and recording vital signs, including blood pressure. • Measuring and recording intake and output, when ordered. • Collecting and testing specimens as directed. *Prior authorization required. See details on page* 76.

Medical Health Services	Coverage and Limits
Personal Emergency Response Systems (PERS)	PERS is a 24-hour emergency assistance service that helps members get immediate help in case of an emergency. PERS items include electronic devices or services designed for emergency assistance. **PERS services are limited to those individuals:** · Who live alone. · Who are alone for significant parts of the day. · Who have no regular caregiver for extended periods. · Who would otherwise need extensive routine supervision. · Who live in a non-licensed setting, except an ALF. *Prior authorization required. See details on page* 76.
Physician services	**Services must be medically necessary and provided at locations including:** · Physicians' offices. · Clinics. · Private homes. · Licensed hospitals. · Licensed skilled nursing facility. · Intermediate care facility. · Licensed or certified residential setting.

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

Medical Health Services	Coverage and Limits
Preventive services	**Services include but are not limited to:** • Initial and interval histories. • Comprehensive physical examinations (including developmental services). • Immunizations. • Family planning. • Diagnostic and screening laboratory. • X-ray services (including screening for tuberculosis). *May require prior authorization. See details on page* 76.
Private-duty nursing	Covered for those who need ongoing nursing care. Service is provided by licensed nurses within the scope of state law. *Prior authorization required. See details on page* 76.
Radiology / laboratory / other diagnostic services	**Covered services include:** • Diagnostic. • Therapeutic radiology and imaging. • Screening and diagnostic laboratory tests. *May require prior authorization. See details on page* 76.

Medical Health Services	Coverage and Limits
Rehabilitation services	**Covered services include:** • Physical and occupational therapy. • Audiology and speech / language therapy. *May require prior authorization. See details on page* 76.
Respite care	**Respite care is short-term based care. It provides relief to caregivers. It may be provided hourly, daily, or overnight. Respite care may be provided in the following locations (based on the current care that the member is getting):** • Member's home or place of residence. • Foster home or expanded-care adult residential care home. • Medicaid-certified nursing facility. • Licensed respite day care facility. • Other community care residential facility approved by the Plan. • Respite care services are authorized by the member's PCP as part of the member's care plan. *Prior authorization required. See details on page* 76.
Smoking cessation	**Covered services include:** • Medication. • Counseling. • Two quit attempts per benefit period.

Medical Health Services	Coverage and Limits
Specialized medical equipment warranty and supplies	**Refers to the purchase, rental, lease, warranty, and supplies costs, installation, repairs, and removal of devices, controls, or appliances that member was already approved for and that was specified in the care plan. This also includes:** • Items necessary for life support. • Supplies and equipment needed for the proper functioning of such items. • Durable and non-durable medical equipment not available under the Medicaid state plan. **Examples include:** • Specialized infant car seats. • Modification of parent-owned motor vehicle to accommodate the child (for example, wheelchair lifts). • Intercoms for monitoring the child's room. • Shower seat. • Portable humidifiers. • Electric bills specific to electrical life support devices (ventilator, oxygen concentrator). • Medical supplies. *Prior authorization required. See details on page* 76.

Medical Health Services	Coverage and Limits
Sterilizations	**Covered if:** • You are at least 21 years of age at the time consent is obtained. • You are mentally competent. • You voluntarily give informed consent by completing the Informed Consent for Sterilization Form. • Your provider completes the Sterilization Required Consent Form. *May require prior authorization. See details on page* 76.
Telehealth services	**Services may include, but are not limited to:** • Real-time video conferencing. • Secure interactive and non-interactive web communication. • Secure transfer of your medical records. Your provider can use high-quality images and lab reports for your care. **Services not covered include:** • Standard phone calls, faxes, or email — in combination or individually — are not considered telehealth services. • Getting your medication by filling out an online form is not a telehealth service. If you get in-person care that needs prior approval, you need prior approval to get the same care through telehealth. Providers will tell you if they provide telehealth services. Your provider bills the plan for these services.

Medical Health Services	Coverage and Limits
Transplant services	Cornea transplants and bone grafts are covered. *May require prior authorization. See details on page* 76. *Other transplants are covered under the State of Hawaii Organ and Tissue Transplant Program, not the QUEST (Medicaid) program.*
Transportation services	**The plan provides emergency and non-emergency ground and air services to and from medically necessary medical appointments for members who:** • Have no means of transportation. • Reside in areas not served by public transportation. • Cannot access public transportation due to their medical condition. • Do not live in a community foster family home, adult residential care home, expanded adult residential care home, or domiciliary home. Transportation is not provided to day programs that are not medically necessary. *To learn more about transportation, see page* 70. *May require prior authorization. See details on page* 76.
Urgent care services	Covered as medically necessary. *May require prior authorization. See details on page* 76.

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

Extra Member Benefits

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

General Educational Development (GED®) or Hawaii HiSET® Exam

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

- You can take the GED® or HiSET® tests at no charge if you're age 18 or older and don't have your high school diploma.
- Visit our website to learn more and find help preparing for the test.

Over-the-Counter (OTC) Supplies

- The OTC benefit is available to each head of household. The $10 per month allowance will roll over if not used, and the funds will remain available until the end of the calendar year.
- You can choose from more than 200 items like diapers, pain relievers, reading glasses, dental kits, and more.
- The items are mailed right to your home.

We have three easy ways to order your OTC items:

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

Asthma Room To Breathe Program

- As part of our Room to Breathe Program, eligible members may get all of the following items and services to help reduce their asthma symptoms and create a safer environment when criteria is met:
  - Hypoallergenic Bedding:
    - » Items include mattress and pillow casings.
    - » Limited to $100 annually per member.
    - » Bedding must be ordered through an 'Ohana Care Coordinator.
  - Carpet Cleaning:
    - » Provides carpet-cleaning service for qualified asthmatic members.
    - » Two carpet cleanings per plan year.
  - HEPA Filter Vacuum Cleaner:
    - » Provides qualified asthmatic members with a vacuum cleaner with a high efficiency particulate air (HEPA) filter, which traps pollutants and may help bring allergy relief.
    - » Limit of one.

  - Allergy Masks:
    - » Provides allergy masks to protect against air pollution.
  - Nutritional Education Counseling.

Ambulatory Blood Pressure Monitoring

- Eligible members at risk for high blood pressure (also known as *hypertension*) can get a blood pressure cuff to check their blood pressure at home.
- Want to learn more? Call us toll-free at **1-888-846-4262** (TTY: **711**). We are here for you Monday through Friday, from 7:45 a.m. to 4:30 p.m., Hawaii Standard Time.

WeightWatchers®

  - ‘Ohana will provide eligible members with two 6-month memberships to WeightWatchers®. Members should be referred by their provider. WeightWatchers is available online, in-person, or a mix of the two.
  - Case Management or Disease Management approval required.
    - » Age 18 years or older with a BMI equal or greater than 25.

Pain Management Program

This program helps qualified members manage chronic pain. If criteria is met, Prior Authorization is needed . Limitations apply (a total of 20 visits per year for services listed below).

- **Acupuncture** is a treatment in which needles are used to stimulate certain points of the body. It can help lessen pain and treat other health conditions.
- **Massage therapy** is when a specialist works with soft body tissues (such as muscles , connective tissue, tendons, and ligaments) to help manage pain.
- **Chiropractic therapy** is manipulation of the spine by a licensed chiropractor to treat pain.

Caregiver Package

‘Ohana provides packages to the caregivers of active members containing:

- Phone numbers.
- Keepsake bag.
- Caregiver educational materials.
- Caregiver journal.
- Information regarding support groups.

Social Call Program

- ‘Ohana links local volunteers with qualifying members. These volunteers engage in ongoing calls with members who would like more social contact.
- Limited to members identified as at risk for social isolation.

Cell Phone: ConnectionsPlus Program

- ʻOhana will give eligible members free smart phones and data through our ConnectionsPlus Program (member must meet all required qualifications to receive this program).
- Limit one smart phone per Member.

My Health Pays® Rewards

Get rewarded for focusing on your health!

Earn My Health Pays® rewards when you complete healthy activities, like your yearly wellness exam, annual screenings, tests, and other things to protect your health. Use Your My Health Pays rewards to help pay for:

- Utilities.
- Telecommunications.
- Education.
- Transportation.
- Childcare services.
- Rent.

Or you can use your rewards to shop at Walmart for everyday items.**

**This card may not be used to buy alcohol, tobacco, or firearms products.

Want to learn more about any of these programs? Call us toll-free at **1-888-846-4262** (TTY: **711**). We are here for you Monday through Friday, from 7:45 a.m. to 4:30 p.m., Hawaii Standard Time.

Services Covered by Other Agencies

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

Mental Health Services

The Child and Adolescent Mental Health Division (CAMHD) helps children ages 3 to 20 who have social, emotional, or behavioral issues. To get services with CAMHD, please call your local Family Guidance Center. You can use the list below to find the center nearest you. Or you can call your health plan Health Coordinator.

Family Guidance Center	Location	Phone Number
Oahu		
Central Oahu	Pearl City	1-808-453-5900
Family Court Liaison Branch	Kailua	1-808-266-9922
Honolulu	Honolulu	1-808-733-9393
Leeward Oahu	Kapolei	1-808-692-7700
Windward Kaneohe	Kaneohe	1-808-233-3770
Hawaii		
Hilo	Hilo	1-808-933-0610

Family Guidance Center	Location	Phone Number
Hawaii		
Kailua Kona	Kealakekua	**1-808-491-9226**
Kauai	Lihue	**1-808-274-3883**
Maui		
Wailuku	Wailuku	**1-808-243-1252**
Molokai	Kaunakakai	**1-808-553-7878**

AMHD stands for Adult Mental Health Division. AMHD runs a 24-hour call center called Hawaii CARES. When you call Hawaii CARES, you can get important information about mental health resources. You also get access to crisis services.

You can call Hawaii CARES toll-free at **1-800-753-6879**. On Oahu, call **1-808-832-3100**.

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

Development Disability Waiver Program

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

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

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

- **1-808-733-1689** in Honolulu, Oahu
- **1-808-241-3406** in Lihue, Kauai
- **1-808-243-4625** in Wailuku, Maui
- **1-808-974-4280** in Hilo, Hawaii

Dental

Dental services are now available to eligible members ages 21 and older. Call Community Case Management Corporation (CCMC) at **1-808-792-1070** or toll-free at **1-888-792-1070**. CCMC can explain the covered dental benefits, help you find a dentist, or coordinate transportation for individuals traveling from the neighboring islands to Oahu.

Some limitations may apply. Prior authorization may be needed.

Covered services include:

Services	Description and Limitation
Preventative services	• Comprehensive oral evaluation: once every five years. • Periodic screening examinations: two per year. • Prophylaxis: two per year. • Topical fluoride or fluoride varnish: two per year.
Diagnostic and radiology services	• Bitewing X-rays: two per year. • Full series X-rays: one every five years. • Periapical X-rays. • Biopsies of oral tissue.
Endodontic therapy services	• Root canal therapy on permanent molars.
Restorative services	• Amalgams on primary and permanent posterior teeth. • Composites on anterior and posterior teeth. • Pin and/or post reinforcement. • Cast cores. • Recement inlays and crowns. • Stainless steel crowns.
Oral surgery	
Periodontal therapy services	• Scaling and root planning: one every 24 months.
Prosthodontic services	• Complete upper and lower dentures: one every five years. • Partial dentures: one every five years. • Denture relines: one every two years. • Repairs.
Emergency and palliative treatment	• Gingivectomy, for gingival hyperplasia. • Other medically necessary emergency dental services.

Transplant

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

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

Intentional Termination of Pregnancy (ITOP)

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

Additional Services for Children

Children may qualify for more services with these programs.

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

Women, Infants and Children (WIC) Program

WIC is a special nutrition program that provides:

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

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

Non-Covered Services

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

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

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

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

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

Non-Covered Services	Exceptions / Limits
Cosmetic procedures	Not covered.
Hysterectomies	**Not covered when:** • Performed solely for the purpose of rendering a member permanently incapable of reproducing. • There is more than one purpose for performing the hysterectomy (but the primary purpose is to render the member permanently incapable of reproducing). • It is performed for the purpose of cancer prevention.
Investigational and experimental procedures	Not covered.
Medical care in a foreign country for children or adults	Not covered.
Radiology / laboratory / other diagnostic services	**Non-covered services include:** • Radiology services – ultrasounds for gender determination. **Laboratory and diagnostic services:** • Experimental. • Investigational or generally unproven. • IgG4 testing. • Procedures related to storing, preparation and transfer of oocytes for *in vitro* fertilization.
Vision services	**Non-covered services include:** • Orthoptic training. • Prescription fee, progress exams. • Radial keratotomy, visual training, and Lasik. • Contacts for cosmetic reasons.

Prescription Drug Services

Prescriptions and Pharmacy Access

How do I get a prescription?

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

Which drugstores will fill my prescription?

Prescriptions must be filled at a drugstore in our network. A list of these drugstores is in your Provider Directory and at **ohanahealthplan.com**. You may also be able to get your prescriptions through 'Ohana's mail-order service. Call 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 copay for prescribed medications for Medicaid-only members. If a drug is covered under your Medicare Part D benefit, you are responsible for the Part D copay. There are certain drugs and OTC medications that are not covered by Medicare Part D that 'Ohana Health Plan QUEST (Medicaid) may cover. Remember to bring your Medicare and/or Medicare Part D and your QUEST (Medicaid) member cards to the pharmacy whenever you fill a prescription.

Preferred Drug List

What medicines do we pay for?

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

Are there medicines we will not pay for?

The plan does not pay for these medicines:

- Those used to help you get pregnant.
- Those used for eating problems, weight loss, or weight gain.
- Those used for erectile dysfunction.
- Those that are used for cosmetic purposes or to help you grow hair.
- Vitamins, except for prenatal vitamins and those listed on the PDL.
- Drug Efficacy Study Implementation (DESI) drugs and drugs that are identical, related, or similar to such drugs.

- Investigational or experimental drugs.
- Those used for any purpose that is not medically accepted.

Can I get any medicine I want?

You can get all medicines that are medically necessary. All drugs your provider orders may be covered if they are on the Preferred Drug List. Please see page 67. You may need to get prior approval if your provider prescribes certain medicines. Call Customer Service with any questions. In some cases, you must try another drug before we approve the one you originally asked for. We may not approve your requested drug if you do not first try the alternative drug.

Are generic drugs as good as brand-name drugs?

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

Other Drugs You Can Get at the Pharmacy

Do we pay for OTC drugs?

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

- Aspirin.
- Ibuprofen (a pain reliever for headaches, toothaches, and back pain).
- Diphenhydramine (for allergy relief).
- Non-sedating antihistamines (allergy relief that won't make you sleepy).
- Insulin.
- Insulin syringes.
- Urine test strips.
- Antacids.
- H-2 receptor antagonist (a type of drug that reduces stomach acid).
- Proton pump inhibitors (a type of drug that reduces stomach acid).
- Multivitamins / multivitamins with iron.
- Iron.
- Topical antifungals.
- Meclizine (a type of drug that helps nausea and dizziness).

See our PDL for a list of all covered OTC drugs. Call Customer Service with any questions you may have.

Pharmacy Direct Member Reimbursement (DMR)

What is a Member Pharmacy Reimbursement?

Sometimes you may pay for medications out of pocket at a retail drugstore. This can happen if you forget to show your ʻOhana QUEST (Medicaid) ID card. After such a purchase, you have 12 months to send us a claim form and receipts to recover your costs. This is called a Pharmacy Direct Member Reimbursement (DMR). To get a copy of the Member Pharmacy Reimbursement claim form, call Customer Service toll-free at **1-888-846-4262** (TTY: **711**). We're here for you Monday through Friday, from 7:45 a.m. to 4:30 p.m., Hawaii Standard Time. You can also visit **ohanahealthplan.com**. The Member Pharmacy Reimbursement claim form is located under the "More Helpful Documents" section.

Where do I send my request?

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

What do I need to include with each Member Pharmacy Reimbursement request ?

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

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

How much will I get back?

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

How long should I expect to wait for my pharmacy reimbursement?

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

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

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

Telehealth Services

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

Services may include:

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

Services not covered include:

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

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

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

Transportation

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

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

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

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

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

Bus service is used if:

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

AND

- You live less than a half-mile from a bus stop;

AND

- Your destination is no more than a half-mile from a bus stop.

Taxi service is used if:

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

OR

- You live more than a half-mile from a bus stop;

OR

- Your destination is more than a half-mile from a bus stop;

TheHandi-Van is used if:

- You live on Oahu;

AND

- You have a condition that does not allow you to ride a bus;

AND

- You are certified for this service.

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

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

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

Questions?

What if your medical provider says you can't ride the bus or TheHandi-Van? What if these services aren't available in your area? If so, we will work with you to find another way to get you where you need to go.

Also, talk with your provider about any ongoing appointments. They can get NET for you.

3 steps for using your transportation benefit

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

NET service reminders

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

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

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

Pharmacy Lock-In Program

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

What is the Pharmacy Lock-In Program?

Seeing many different providers for your care can be dangerous if each provider gives you similar drugs without knowing what the other providers are prescribing. We want you to have a clear understanding of these possible dangers and protect you from that.

If we see that you are in that situation, this program will help you more effectively manage your prescription drug and medical care needs. If you are identified for this program, you will get all of your controlled substance prescriptions from one assigned pharmacy and/or one prescriber. This will help your pharmacist and provider understand your prescription needs.

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

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

As part of the ʻOhana Pharmacy Lock-In Program, you have access to a Care Team for more support. A Health Coordinator can work with you to create a personal Care Plan. Coordinators provide monitoring, education, communication, and collaboration, and can help with access to other treatments to improve your health. There is no cost to you for this voluntary service.

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

Health Coordination

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

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

When you join ‘Ohana Health Plan, you will get a welcome call. This call will help you get the right PCP and identify any cultural needs. We will also make sure you got your ‘Ohana ID card and will answer any questions you may have about the information in this handbook. Finally, we will do a screening to see if you have any special healthcare needs, if you need help managing your health, or if you should start working with a Health Coordinator. You may also be referred to a Disease Management program.

We will ask you to work with a Health Coordinator if we think you would benefit from having someone to help with your care. Health Coordinators work with your PCP. They make sure you can get any covered services you may need.

This program may be good for you if you:

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

Your Health Coordinator will get in touch with you to learn about your health history and your existing services. This helps us match you up with the Health Coordinator who best meets your needs. Then they will call you to set up an in-person visit to learn more about your needs.

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

You can call your Health Coordinator toll-free at **1-888-846-4262** (TTY: **711**). We are here for you Monday through Friday, from 7:45 a.m. to 4:30 p.m., Hawaii Standard Time. Your Health Coordinator will return your call within three days.

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

Disease Management

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

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

We have programs for:

- Diabetes mellitus.
- Asthma.
- High blood pressure (*hypertension*).
- Quitting smoking (referral to the Hawaii Tobacco Quit Line).
- Congestive heart failure.

Any member with these conditions may join this program at no cost. Your Health Coordinator or provider may refer you to the Disease Management Program, or you can join directly at any time. This program enhances the care you get from your provider. It does not replace any service.

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

Behavioral Health Services

We can help if you or someone in your family is having trouble with mental health issues or substance use. Call your Health Coordinator or Customer Service to find out more. Our staff will be happy to help you. You do not need prior approval from your PCP. We will give you names of providers near you. You may choose from these names to set up an appointment.

What to Do if You Are Having a Problem

You should call us if you have any of these problems. We can get you help 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, stomachache, and backaches.

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

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

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

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

Behavioral Health Limitations and Exclusions

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

Hospital Services

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

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

Other ʻOhana Programs

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

- Programs to stop smoking.
- Drug and alcohol programs.
- Domestic abuse support.
- Programs for pregnant women and their babies.
- Programs for kids.

How to Get Services

Services That Require a Referral

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

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

What is a Referral?

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

Services Available Without a Referral (Self-Referral Services)

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

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

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

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

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

Services From Providers Not in Our Network

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

Services That Require Prior Authorization/Precertification

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

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

- Certain medical supplies and equipment.
- Certain medical procedures done by your PCP or specialist.
- Referrals to a case management agency and/or foster home placement.
- Referrals or admission to a nursing home or residential home.

- Chemotherapy.
- Surgical procedures.
- Cosmetic procedures.
- Non-emergency hospital services.
- Any out-of-plan services or non-network care.
- Home and community-based services.

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

Utilization Management Program

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

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

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

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

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

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

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

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

Second Medical Opinion

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

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

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

You can also call the 24-Hour Nurse Advice Line toll-free at **1-800-919-8807**. (See the *Nurse Advice Line* section on page 25.)

Emergency Services

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

Below is a list of hospitals with emergency service providers.

Facility Name	Address	City	State	Zip Code	Island	Phone Number
Hale Hoola Hamakua	45-547 Plumeria St	Honokaa	HI	96727	Hawaii	**1-808-932-4100**
Hilo Medical Center	1190 Waianuenue Ave	Hilo	HI	96720	Hawaii	**1-808-974-4700**
Kau Hospital	1 Kamani St	Pahala	HI	96777	Hawaii	**1-808-932-4200**
Kohala Hospital	54-383 Hospital Rd	Kapaau	HI	96755	Hawaii	**1-808-889-6211**
Kona Community Hospital	79-1019 Haukapila St	Kealakekua	HI	96750	Hawaii	**1-808-322-9311**
Queens North Hawaii Community Hospital	67-1125 Mamalahoa Hwy	Kamuela	HI	96743	Hawaii	**1-808-885-4444**

Facility Name	Address	City	State	Zip Code	Island	Phone Number
Kauai Veterans Memorial Hospital	4643 Waimea Canyon Rd	Waimea	HI	96796	Kauai	**1-808-338-9431**
Samuel Mahelona Memorial Hospital	4800 Kawaihau Rd	Kapaa	HI	96746	Kauai	**1-808-822-4961**
Wilcox Memorial Hospital	3-3420 Kuhio Hwy	Lihue	HI	96766	Kauai	**1-808-245-1100**
Lanai Community Hospital	628 Seventh St	Lanai City	HI	96763	Lanai	**1-808-565-6411**
Kula Hospital	100 Keokea Pl	Kula	HI	96790	Maui	**1-808-878-1221**
Maui Memorial Medical	221 Mahalani St	Wailuku	HI	96793	Maui	**1-808-244-9056**
Molokai General Hospital	280 Home Olu Pl	Kaunakakai	HI	96748	Molokai	**1-808-553-5331**
Adventist Health Castle	640 Ulukahiki St	Kailua	HI	96734	Oahu	**1-808-263-5500**
Kahuku Medical Center	56-117 Pualalea St	Kahuku	HI	96731	Oahu	**1-808-293-9221**
Kapiolani Medical Center For Women And Children	1319 Punahou St	Honolulu	HI	96826	Oahu	**1-808-983-6000**
Kuakini Medical Center	347 N Kuakini St	Honolulu	HI	96817	Oahu	**1-808-536-2236**
Pali Momi Medical Center	98-1079 Moanalua Rd	Aiea	HI	96701	Oahu	**1-808-486-6000**
Straub Clinic Hospital	888 S King St	Honolulu	HI	96813	Oahu	**1-808-522-4000**
The Queens Medical Center	91-2141 Fort Weaver Rd	Ewa Beach	HI	96706	Oahu	**1-808-691-3000**
The Queens Medical Center	1301 Punchbowl St	Honolulu	HI	96813	Oahu	**1-808-691-1000**
The Queens Medical Center	128 Lehua St	Wahiawa	HI	96786	Oahu	**1-808-621-8411**

For a full list of emergency service providers, please Call Customer Service, check your Provider Directory, or visit **ohanahealthplan.com**.

To use the "Find a Provider / Pharmacy" tool on our website, go to ohanahealthplan.com and follow these directions:

1. Click "Find a Provider / Pharmacy."
2. Enter your Zip Code.
3. Select "Medicaid" as your coverage and plan, and press "Continue."
4. Select your plan. Choose either:
   - **a.** ʻOhana Community Care Services (CCS); or
   - **b.** ʻOhana QUEST Integration.
5. Select where you want to search:
   - **a.** You may choose city and state, island, zip code, or address.
   - **b.** Then set the distance from your location that you would like to search.
6. Select what you're looking for:
   - **a.** Type in the specialty, urgent care, emergency care, etc.
7. Click "Go to Results."

What to Do in an Emergency

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

- Sudden heavy blood loss.
- Heart attack.
- Cuts that need stitches.
- Passing out.
- Poisoning.
- Severe chest pains.
- When you can't breathe.
- Broken bones.

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

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

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

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

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

Post-Stabilization Services

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

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

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

Out-of-Area Emergency Care

If you have an emergency while traveling within the United States, go to the nearest hospital. Show your ID card. Call your PCP as soon as you can. Ask the hospital staff to call us. If you have to pay for care while you are out of the service area, send your claim to our Claims Department. We will need copies of your medical reports and the bills. We also will need proof of payment. You have up to one year to ask to be repaid. You have up to one year to send us your request.

If you get sick or hurt while outside of the ʻOhana service area and it is not an emergency, call your PCP.

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

What to Do if You Need Urgent Care

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

- Injury
- Illness
- Severe pain

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

Out-of-State and Off-Island Coverage

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

This includes:

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

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

Call Customer Service toll-free at **1-888-846-4262** (TTY: **711**) if you get sick or hurt or need medically necessary EPSDT (for members younger than the age of 21) services while you are out of the ʻOhana service area and It is not an emergency. We will help you get the care you need and make sure you get approval before getting services.

Pregnancy and Newborn Care

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

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

You must choose a PCP for your baby. You should do this by the time the baby is born. If you have any questions, please call Customer Service toll-free at **1-888-846-4262** (TTY: **711**). We are here for you Monday through Friday, from 7:45 a.m. to 4:30 p.m., Hawaii Standard Time.

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

Transition of Care

If you are new to ʻOhana or your PCP is no longer participating with ʻOhana, we can work with you and your PCP so that you keep getting services as we move you to a participating provider.

If you are leaving ʻOhana, we can help with your transition. Please call Customer Service to help arrange the transition you need.

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

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

- Preventive care for members from newborn through age 20.
- Services and medications.
- Lab tests (as needed).
- Prescriptions (as needed).

- A comprehensive history and physical exam.
- Behavioral and mental health assessment.
- Growth and development chart.
- Vision, hearing, and language screening.
- Nutritional health and education.
- Lead risk assessment and testing, as appropriate.
- Age-appropriate vaccines (immunizations).
- Dental screening and referral to dentist.
- Referral to specialists and treatment, as appropriate.
- Intensive behavioral therapies, such as applied behavioral analysis (ABA) services for members with an autism spectrum disorder (ASD) diagnosis.
- Any needed services as part of a treatment plan that is approved as medically necessary by the plan.
- Regular preventive dental and treatment services, including screening examinations and prophylactic treatment (scaling and polishing), following the Academy of Pediatric guidelines.

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

What is a well-child checkup?

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

- Do a full 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 their 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 can help find health concerns before they become bigger problems. Your child can also get the shots they need during these visits.

When should a well-child checkup occur?

Your child should visit their PCP for well-child checkups as recommended by the American Academy of Pediatrics. Your child should go to these visits even if they feel well.

How much does a well-child checkup cost?

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

What if I need help getting a provider visit?

We can help you get an appointment. Just call Customer Service toll-free at **1-888-846-4262** (TTY: **711**). We're here for you Monday through Friday, from 7:45 a.m. to 4:30 p.m., Hawaii Standard Time.

What if I need help getting a ride?

We can help you get a ride to the provider. Call Customer Service toll-free at **1-888-846-4262** (TTY: **711**). We're here for you Monday through Friday, from 7:45 a.m. to 4:30 p.m., Hawaii Standard Time.

Pediatric Preventive Health Guidelines

Listed below are resources for preventive pediatric care services. These tell you when you and your family should get checkups, tests, and shots.

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

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

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

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

The following resources include recommendations published by the American Academy of Pediatrics and Bright Futures and the Centers for Disease Control and Prevention.[1,2]

- Recommendations for Preventive Pediatric Health Care: **www.aap.org/en/practice-management/care-delivery-approaches/periodicity-schedule**
- Recommended Immunization Schedule for Persons aged birth to 18 years old: **https://www.cdc.gov/vaccines/hcp/imz-schedules/downloads/child/0-18yrs-child-combined-schedule.pdf**

References

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

[2] *Centers for Disease Control and Prevention, published annually. Recommended immunization schedule for persons aged birth to 18 years old.*

Adult Preventive Health Guidelines

Frequency of Physical Exams

All new members should get a physical exam in the first 90 days of enrollment. *Pregnant members should be seen in the first 14 days of enrollment.*

The following chart includes recommendations published by the U.S. Preventive Services Task Force (USPSTF) and the Centers for Disease Control and Prevention.[1,2]

Age	Screening	Frequency
Members ages 18 and older.	Blood pressure, height, body mass index (BMI), and alcohol use.	Annually or per PCP recommendations.
Adults ages 21 years and older, especially if at high risk.	Cholesterol.	Every four to six years (more frequent if elevated).
Adults ages 21 years and older, especially if at high risk.	Cervical cancer screening.	Every three years or per PCP's recommendations.
Adults ages 40 years and older.	Mammography.	Every one to two years.
Adults ages 45-75 years.	Colorectal cancer screening.	Dependent upon test.
Adults ages 65 years and older, or younger than 65 years and at risk.	Osteoporosis (bone mass measurement).	Per PCP recommendations

Immunizations

- Adult Immunization Schedule: Recommendations for Ages 19 years or older: **www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf**

References

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

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

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

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

Advance Directives

Your Care is Your Decision

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

Advance Directives Help You Make Your Wishes Known

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

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

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

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

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

Where can I get an advance directives form?

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

How can I learn more about advance directives?

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

Can I change my advance directive?

Yes, you can change your advance directive at any time. You may want to contact a lawyer for help. It is a good idea to look over your advance directive from time to time to make sure it still says what you want and covers all areas.

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

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

Do my caregivers have to follow my advance directives?

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

What happens if my wishes aren't followed?

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

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

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

Member Grievance and Appeal Procedures

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

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

Grievances

What is a grievance?

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

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

How do I file a grievance?

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

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

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

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

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

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

When can I file a grievance?

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

'Ohana Health Plan
Attn: Grievance Department
820 Mililani Street
Suite 200
Honolulu, HI 96813

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

State Grievance Review

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

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

Oahu: **1-808-692-8094** (TTY: **1-808-692-7182**)

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

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

Appeals

What is an appeal?

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

- If we deny or limit a service you or your provider asks us to approve.
- If we reduce or stop services you have been getting that we already approved.
- If we do not pay for the healthcare services you get.
- If we fail to give services in the required 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 a resolution on a grievance in the required timeframe.
- If we do not agree to let you see a provider that is not in our network and you live in a rural area or in an area with limited providers.
- If you want to dispute a financial liability.

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

How do I file an appeal?

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

There is only one level of appeal with the Plan.

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

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

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

What if I need an *expedited* (fast) appeal?

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

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

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

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

What if I would like to submit additional information?

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

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

What if I do not like an appeal decision?

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

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

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

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

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

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

- An appeal was requested within 60 calendar days from the date you receive your Notice of Adverse Benefit Determination letter.
- Your appeal or request for a State Administrative Hearing involves an action we are taking to stop or reduce services we had already approved.
- The services were ordered by an authorized provider.
- The original time frame covered by the approval we gave has not ended yet.
- You request that we continue your services in a timely manner, defined as on or before the later of the following:
  - Within 10 calendar days of the date we mailed you the Notice of Adverse Benefit Determination letter; or
  - The date we planned to stop or reduce your service(s).

We will continue your benefits until:

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

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

Important Member Information

Enrollment Information

Enrollment

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

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

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

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

Here are some of the items you may need:

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

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

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

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

Reinstatement

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

Plan Structure, Operations and Provider Incentive Programs

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

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

How Our Providers are Paid

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

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

Medical Services Direct Member Reimbursement (DMR)

What is a Member Medical Reimbursement? **This is for eligible out-of-pocket medical expenses.** After such a purchase, you have 12 months from the date of service to send us a Member Medical Reimbursement claim form and receipts to recover your costs.

To get a copy of the Member Medical Reimbursement claim form, call Customer Service toll-free at **1-888-846-4262** (TTY: **711**). We’re here for you Monday through Friday, from 7:45 a.m. to 4:30 p.m., Hawaii Standard Time. You can also visit **ohanahealthplan.com**. The Member Medical Reimbursement claim form is located under the “More Helpful Documents” section. Please submit one form per member.

Mail the form to:
‘Ohana Health Plan
‘Ohana Member Reimbursement Department
P.O. Box 31381
Tampa, FL 33631-3381

Email the form to: **Memberreimbursements@Wellcare.com**

Or fax form and required documents to: **1-813-283-3284**

Please contact Customer Service toll-free at **1-888-846-4262** (TTY: **711**) if your reimbursement request is for hearing, transportation, or vision services. We’re here for you Monday through Friday, from 7:45 a.m. to 4:30 p.m., Hawaii Standard Time.

For the reimbursement of medical services, FOLLOW THESE INSTRUCTIONS CAREFULLY:

A **Completion of the Member Medical Reimbursement claim form:**

- Print your name and Member ID number as shown on your ‘Ohana ID Card.
- Provide your mailing address and telephone number.
- Describe why you are asking for reimbursement.
- Provide the date of service for which you are requesting reimbursement. This is the date the service was given. List separately each date of service or admission date for inpatient / hospital stays.
- Print the name of the doctor or facility that provided the service.
- Provide a brief description of the service that was provided.
- List the amount requested for the individual service line.
- Add all individual lines together and provide the total amount requested for the reimbursement of all services.

B **Each itemized bill MUST include all the following information:**

- Date of each service.
- Place of each service, such as a doctor's office, independent laboratory, outpatient hospital, inpatient hospital, nursing home, or the patient's home.
- Description of each surgical or medical service or supply furnished.
- Charge for EACH service.
- Doctor or supplier's name and address. Many times a bill will show the names of several doctors or suppliers. IT IS VERY IMPORTANT THAT YOU IDENTIFY THE ONE WHO TREATED YOU. Simply circle their name on the bill.

C **Proof of payment documentation:**

- Copy of canceled check (front and back).
- Credit card statement showing provider as paid.
- Invoice / statement from provider showing provider's name, address, and telephone number.

Evaluation of New Technology

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

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

The review of new technology is done in these areas:

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

To learn more, call Customer Service.

Quality and Member Satisfaction Information

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

Fraud, Waste and Abuse

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

Here are some other examples of fraud, waste, and abuse:

- Billing for a more expensive service than what was actually given.
- Billing more than once for the same service.
- Billing for services not actually performed.
- Falsifying a patient's diagnosis to justify tests, surgeries, or other procedures that are not medically necessary.
- Filing claims for services or medications not received.
- Forging or altering bills or receipts.
- Misrepresenting procedures performed to obtain payment for services that are not covered.
- Overbilling the plan.
- Using someone else's 'Ohana ID card to get services.
- Waiving patient copays or deductibles.
- Obtaining medications and then selling the medications to someone else.
- Requesting and receiving transportation services to go somewhere other than to a medical appointment.

If you think or know that fraud, waste, or abuse has occurred, tell us. We will determine if something is fraud, waste, or abuse. Call our 24-hour Fraud Hotline. The toll-free number is **1-866-685-8664** (TTY: **711**). It is private and you may leave a message without leaving your name. If you do leave your phone number, we will call you back. We do this to be sure our information is complete and accurate. You can also report fraud on our website. Submitting a report online is private. Go to **ohanahealthplan.com**.

You can also send a report in writing to:

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

Digital Health Records

What are my options for managing my digital health records?

In 2021, a new federal rule made it easier for members* to manage their digital health records.

You now have full access to your health records on your mobile device, at no charge. This allows you to manage your health better and to know what resources are available to you.

**Beginning in 2022, the Payer-to-Payer Data Exchange portion of this rule allows former and current members to request that their health records go with them as they switch health plans. For more information about this rule, visit the Payer-to-Payer Data Exchange section found on the webpage below.*

The new rule makes it easy to find information on:**

- Claims (paid and denied).
- Specific parts of your clinical information.
- Pharmacy drug coverage.
- Healthcare providers.

***You can get information for dates of service on or after Jan. 1, 2016.*

For more info, please visit: **ohanahealthplan.com/members/medicaid/quest-integration/benefits/interoperability-and-patient-access.html**

Member Rights and Responsibilities

As an ʻOhana member, you have the right:

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

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

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

Note

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

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

You also have responsibilities as a member:

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

'ohana health plan™

1-888-846-4262 (TTY: **711**)

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