

Hawaii Member Handbook

QUEST (MEDICAID)

Beyond Healthcare. A Better You.





‘Ohana 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 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**). We are here 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 online 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 'Ohana 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 pharmacies 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:

'Ohana 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 'Ohana Offices

'Ohana 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 (Transdev Health Solutions)	1-866-790-8858
Transportation Ride Assist Line (Transdev Health Solutions)	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 (UM) guidelines.
- Member 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 (OTC) order.
- Contact your health coordinator.
- Get a copy of your service plan.
- 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 'Ohana Glossary

WORDS/PHRASES

abuse: Any practices that are inconsistent with sound fiscal, business, or medical practice and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations (including the terms of the RFP, contracts and requirements of state and federal regulations) for healthcare in the managed care setting. Incidents or practices of providers that are inconsistent with professionally recognized standards for healthcare. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

acute care: Short-term medical treatment provided under the direction of a physician, usually in an acute care hospital, for members having an acute illness or injury.

advance directive: A 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).



WORDS/PHRASES

copayment (copay): The amount that a Member shall pay, usually a fixed amount of the cost of a service.

cost sharing: How much you must pay when getting care from 'Ohana 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 'Ohana.

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 individual, the health of the pregnant individual 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.
6. With respect to a pregnant individual 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 their unborn child.

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



WORDS/PHRASES

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

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.
- 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 skilled 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 daycare 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.

'Ohana ID card: An ID card that shows you are a member of our plan.

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

over-the-counter (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 'Ohana 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 healthcare 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 (especially for pregnant individuals) 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.
- 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 'Ohana member ID card in the mail. Keep this card and your Medicaid card with you at all times.

The diagram shows a sample Ohana Health Plan ID card with callouts pointing to specific information:

- Your name:** Points to the member name: **SAMPLE A SAMPLE**.
- Your 'Ohana ID number:** Points to the Member ID: **123456**.
- Your PCP's contact information:** Points to the Primary Care Provider (PCP) details: [Phy Name], [Phy Add1], [Phy Add2], [Phy City, State, Zip], and PCP Phone: 1-XXX-XXX-XXXX.
- How to contact us:** Points to the contact information at the bottom of the card, including the website www.ohanahealthplan.com, Ohana Health Plan address (820 Mililani Street, Suite 200, Honolulu, HI 96813), and phone numbers for Customer Services (1-888-846-4262) and Nurse Advice Line (1-800-919-8807).
- Your Medicaid ID number:** Points to the Medicaid #: **1234567890**.
- The date your 'Ohana membership started:** Points to the Effective Date: **01/01/2025**.
- Information your PCP and other providers need to correctly bill for your care/services:** Points to the OTC Eligible status and other provider codes like RxBIN, RxPCN, and RxGRP.

You need to show 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 'Ohana Customer Service as soon as possible if:

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



2 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 with you 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.

3 Choosing your PCP

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

If you do not choose a PCP, we will assign one to you. The assignment is based on:

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

Remember: If you have Original Medicare or a Medicare Advantage plan, you do not need to pick a PCP for QUEST (Medicaid).

4 Changing your PCP

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

If you change your PCP between the 1st and 10th of the month, the change 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 our provider directory.
- Visit **findaprovider.ohanahealthplan.com**.
- Call Customer Service.

Have Questions?
Our Customer Service agents know about Medicare and Medicaid. We can help you understand how these two plans work together. Call us toll-free at **1-888-846-4262 (TTY: 711)**.



Customer Service or the online provider directory will have the most up-to-date information about our provider network, including information such as name, address, telephone numbers, languages spoken, sex, specialty, and board certification status. A Customer Service agent can also tell you about a provider's schooling or residency, qualifications, or whether they are taking new patients.

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 PCP

Your PCP is your personal provider. 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 (APRN) 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 **findaprovider.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.

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

If you scheduled an appointment with your PCP and cannot attend, please call your PCP as soon as possible 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.



7 Get to know our 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.

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 or 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 77. 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.

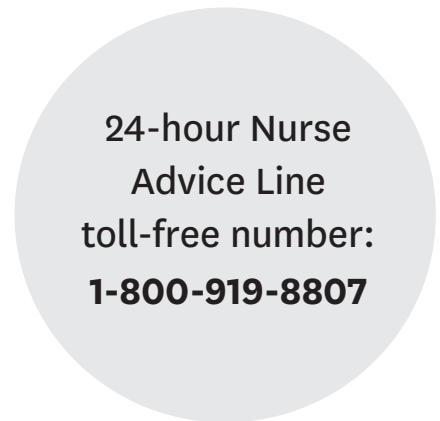
You may leave a non-urgent message after hours. We will return your call within one business day. You can also contact Customer Service by writing to:



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, if you are sent to a state mental hospital, Hawaii Youth Correctional Facility, or prison.

10 ‘Ohana members have certain rights and responsibilities

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

You can now begin using all of the benefits you get with ‘Ohana. 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 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/GYNs, 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 pharmacies	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 10 working days.

Your Financial Responsibilities

Cost sharing

Members may have to share 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 are typically paid to a long-term care facility or home, or to a 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 more details.

You may be billed directly by your provider for any non-covered services or for covered services that exceed established limits, as applicable. Please see the *Covered Services* and *Non-Covered Services* sections of this handbook for more 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 provider and cannot attend, please call their office as soon as you can. 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
<p>Inpatient and outpatient mental health and substance use</p>	<p>Covered services include all medically necessary behavioral health services for QUEST (Medicaid) members:</p> <ul style="list-style-type: none">· 24-hours-a-day care for acute psychiatric illnesses, including:<ul style="list-style-type: none">– 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:<ul style="list-style-type: none">– 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
<p>Inpatient and outpatient mental health and substance use (continued)</p>	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> – 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. <p><i>May require prior authorization. See details on page 75.</i></p>
<p>Additional behavioral health services</p>	<p>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:</p> <ul style="list-style-type: none"> • Health coordination. • Psychosocial rehabilitation. • Clubhouse. • Peer support. • Supported employment. • Partial or intensive outpatient hospitalization. <p><i>Prior authorization required. See details on page 75.</i></p>



Medical Health Services	Coverage and Limits
Acute inpatient hospital care	<p>Includes the cost of room and board for inpatient stays for:</p> <ul style="list-style-type: none">• Nursing care.• Medical supplies.• Equipment.• Drugs.• Diagnostic services.• Physical and occupational therapy.• Audiology.• Speech-language pathology services.• All other medically necessary services. <p><i>May require prior authorization. See details on page 75.</i></p>
Adult day care	<p>Adult day care refers to regular supportive care provided to four or more adult participants who have disabilities.</p> <p>Services include:</p> <ul style="list-style-type: none">• Observation and supervision by center staff.• Coordination of behavioral, medical, and social plans, as well as the implementation of any instructions listed in the participant’s care plan.• Therapeutic, social, educational, recreational, and other activities. <p><i>Prior authorization required. See details on page 75.</i></p>



Medical Health Services	Coverage and Limits
<p>Adult day health</p>	<p>Adult day health services are organized day programs for therapeutic, social, and health services provided to adults with physical or mental impairments (requires nursing oversight or care). This includes:</p> <ul style="list-style-type: none"> • 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. <p><i>Prior authorization required. See details on page 75.</i></p>
<p>Assisted living services</p>	<p>Assisted living services include:</p> <ul style="list-style-type: none"> • Personal care. • Supportive care services (homemaker, chore, attendant services, and meal preparation). <p>The health plan is not responsible for payment of room and board.</p> <p><i>Prior authorization required. See details on page 75.</i></p>



Medical Health Services	Coverage and Limits
At-risk services	<p>Some ‘Ohana 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 having to live in a nursing home, the member is considered “at-risk.”</p> <p>The member must live at home and meet the “at-risk” criteria following an assessment by the member’s provider or health coordinator.</p> <p>At-risk services potentially may include:</p> <ul style="list-style-type: none">• Home-delivered meals.• Personal Emergency Response System (PERS).• Personal assistance services levels 1 and 2.• Adult day care.• Adult day health.• Private duty nursing. <p>Criteria for each of these services and Med-QUEST Division approval must be met to qualify for these services.</p> <p><i>Prior authorization required. See details on page 75.</i></p>
Cognitive rehabilitation services	<p>Services provided to individuals with cognitive impairments that are meant to assess and treat:</p> <ul style="list-style-type: none">• Communication skills.• Cognitive and behavioral abilities.• Cognitive skills related to performing ADLs. <p>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)</p> <p><i>Prior authorization required. See details on page 75.</i></p>



Medical Health Services	Coverage and Limits
<p>Community care foster family home (CCFFH) services</p>	<p>Covered services include:</p> <ul style="list-style-type: none"> • Personal care. • Homemaker services. • Companion services. • Day programming. • Supportive services. • Attendant care. • Local transportation. • Medication oversight (to the extent permitted under state law). <p>All services must be provided in a certified private home by a principal care provider who lives in the home.</p> <p><i>Prior authorization required. See details on page 75.</i></p>
<p>Community care management agency (CCMA)</p>	<p>Covered for members living in community care, foster family homes, and other community settings, as required.</p> <p><i>Prior authorization required. See details on page 75.</i></p>



Medical Health Services	Coverage and Limits
<p>Community Integration Services Plus (CIS+)</p>	<p>Community Integration Services (CIS) provides case management help to find and maintain housing.</p> <p>Covered for members ages 18 years and older who are homeless or at risk of becoming homeless. Members will be assessed to see if they meet eligibility criteria.</p> <p>Services are divided into three categories:</p> <p>1. Pre-tenancy services, such as:</p> <ul style="list-style-type: none">- Screening and assessments.- Developing a housing support plan.- Housing search.- Applications prep and submission.- Identifying resources / costs for start-up needs.- Identifying equipment, technology, and other modifications needed.- Ensuring housing is safe.- Moving assistance.- Individualized housing crisis plan. <p>2. Tenancy services, such as:</p> <ul style="list-style-type: none">- Individual housing and tenancy sustaining services.



Medical Health Services	Coverage and Limits
<p>Community Integration Services Plus (CIS+) (continued)</p>	<p>3. Other housing and tenancy support services, such as:</p> <ul style="list-style-type: none"> – 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. <p><i>May require prior authorization. See details on page 75.</i></p>



Medical Health Services	Coverage and Limits
<p>Counseling and training</p>	<p>Counseling and training activities include:</p> <ul style="list-style-type: none">• 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. <p>Counseling and training is a service provided to:</p> <ul style="list-style-type: none">• Members.• Families or caregivers on behalf of the member.• Professional and paraprofessional caregivers on behalf of the member. <p><i>Prior authorization required. See details on page 75.</i></p>



Medical Health Services	Coverage and Limits
<p>Dental services to treat medical conditions</p>	<p>Health plan emergency covered services include:</p> <ul style="list-style-type: none"> • 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. <p><i>May require prior authorization. See details on page 75.</i></p> <p>All other dental services for adults and children are coordinated through Community Case Management Corp. (CCMC), which helps members:</p> <ul style="list-style-type: none"> • Find a dentist. • Explain the covered dental benefits. <p><i>See Services Covered by Other Agencies on page 74.</i></p>



Medical Health Services	Coverage and Limits
<p>Dialysis</p>	<p>Covered services and medical supplies include, but are not limited to:</p> <ul style="list-style-type: none"> • Services. • Equipment and supplies. • Diagnostic testing. • Drugs (medically necessary). <p>Services may be provided in a hospital inpatient setting, in a hospital outpatient setting, in a non-hospital renal dialysis facility, or in the member’s home.</p>
<p>Durable medical equipment (DME) and medical supplies</p>	<p>Covered services and medical supplies include, but are not limited to:</p> <ul style="list-style-type: none"> • 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 DME. <p><i>May require prior authorization. See details on page 75.</i></p>
<p>Early and Periodic Screening Diagnostic and Treatment (EPSDT)</p>	<p>Please see the <i>Well-Child Care and EPSDT (Early and Periodic Screening, Diagnostic and Treatment) Services</i> section on page 82 for details on child health checkups.</p>



Medical Health Services	Coverage and Limits
<p>Emergency services</p>	<p>Covered for medically necessary services. Includes any screening examination services to find out whether an emergency medical condition exists.</p> <p><i>Prior authorization is not required.</i></p>
<p>Environmental accessibility adaptations</p>	<p>Covered services include:</p> <ul style="list-style-type: none"> • 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. <p>Excluded are changes or improvements to the home that do not have a direct medical or remedial benefit to the member, such as:</p> <ul style="list-style-type: none"> • Carpeting. • Roof repair. • Central air conditioning. • Changes that add square footage to the home. <p>All services shall comply with state or local building codes.</p> <p><i>Prior authorization required. See details on page 75.</i></p>



Medical Health Services	Coverage and Limits
Family planning services	<p>Covered services include:</p> <ul style="list-style-type: none">• 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. <p>Family planning does not require a referral from your PCP. Certain procedures may require prior authorization. See details on page 75.</p> <p>‘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.</p>
Fluoride varnish	Topical fluoride varnish for children ages 1 to 6 only if they did not get topical fluoride treatments in the previous six months.



Medical Health Services	Coverage and Limits
<p>Habilitative services and devices</p>	<p>When medically necessary, covered services and devices include:</p> <ul style="list-style-type: none"> • Audiology services. • Occupational therapy. • Physical therapy. • Speech / language therapy. • Vision services. <p>Examples may include:</p> <ul style="list-style-type: none"> • Augmentative communication devices. • Reading devices. • Visual aids. <p>These are excluded when used specifically for activities at school when medical necessity has not been established.</p> <p>Habilitative services do not include coverage for routine vision services.</p> <p><i>May require prior authorization. See details on page 75.</i></p>
<p>Health education and counseling</p>	<p>Covered services include:</p> <ul style="list-style-type: none"> • Substance use, including alcohol. • Diet and exercise. • Injury prevention. • Sexual behavior. • Dental health. • Family violence. • Depression. • Results and implications of screenings listed above. <p><i>May require prior authorization. See details on page 75.</i></p>



Medical Health Services	Coverage and Limits
Hearing	<p>Hearing services include:</p> <ul style="list-style-type: none">• Screening.• Diagnostic.• Corrective services, equipment, and/or supplies. <p>For adults 21 years and older:</p> <ul style="list-style-type: none">• Fitting.• Orientation.• Hearing aid check (once every three years). <p>For children under age 21:</p> <ul style="list-style-type: none">• Fitting.• Orientation.• Hearing aid check (two per three years). <p><i>Prior authorization is required for all hearing aid devices.</i></p>
Home health services	<p>Some home health services included are:</p> <ul style="list-style-type: none">• Skilled nursing.• Home health aides.• Medical supplies and DME.• Physical and occupational therapy.• Rehabilitation services.• Audiology and speech / language pathology. <p><i>May require prior authorization. See details on page 75.</i></p>



Medical Health Services	Coverage and Limits
<p>Home maintenance</p>	<p>Home maintenance services are those services not included as part of personal assistance and include:</p> <ul style="list-style-type: none"> • 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. <p><i>Prior authorization required. See details on page 75.</i></p>
<p>Home-delivered meals</p>	<p>Includes nutritious meals delivered to where the member lives. Cannot be delivered to residential or institutional settings. No more than two meals per day.</p> <p><i>Prior authorization and level of care requirements needed. See details on page 75.</i></p>
<p>Hospice services</p>	<p>Provides care to terminally ill patients who have a life expectancy of six or fewer months as determined by their provider.</p> <p>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.</p> <p>Children under the age of 21 can receive treatment to manage or cure their disease while concurrently receiving hospice services.</p> <p><i>May require prior authorization. See details on page 75.</i></p>



Medical Health Services	Coverage and Limits
Hysterectomies	<p>Covered under the following requirements:</p> <ul style="list-style-type: none">• 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	<p>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:</p> <ul style="list-style-type: none">• 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
<p>Long-term care – institutional services</p>	<p>Based on member’s enrollment category as determined by the Department of Human Services (DHS).</p> <p><i>Prior authorization required. See details on page 75.</i></p>
<p>Medication assisted treatment (MAT)</p>	<p>Includes the provision of methadone or buprenorphine products and related outpatient counseling services for Opioid Use Disorder.</p>
<p>Maternity services</p>	<p>Covers:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> – Screening, brief intervention, and referral treatment (SBIRT). – Screening for maternal depression. – 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
<p>Medical respite services</p>	<p>Medical respite services give people a safe place to stay for a short time when they need help before or after a medical event. These services include housing, medical care, and support. Respite services are not meant for long-term care. Members may use these services for up to six months total in a 12-month period.</p> <p>There are three types of medical respite services:</p> <p>Pre-procedure housing:</p> <ol style="list-style-type: none">1. For people who need care before or after a planned medical procedure or treatment that requires care prior to or following the procedure or treatment.<ol style="list-style-type: none">a. Stay for up to seven days before and three days after the procedure.b. Longer stays may need a different type of care. <p>Recuperative care:</p> <ol style="list-style-type: none">2. For people who need medical help with ongoing medical or mental health needs.<ol style="list-style-type: none">a. Stay can be for up to 90 days in a row.b. Can be used again if needed, as long as the member stays within the six-month limit. <p>Post-hospitalization housing:</p> <ol style="list-style-type: none">3. For people recovering after leaving a hospital or treatment center.<ol style="list-style-type: none">a. There is no separate time limit, but it counts toward the six-month limit. <p><i>Prior authorization needed. See details on page 75.</i></p>



Medical Health Services	Coverage and Limits
<p>Moving assistance</p>	<p>Help moving is offered when the health coordinator finds that a member needs to move to a new home to prevent the member’s health from getting worse. For Long Term Services and Support (LTSS) members, this includes:</p> <ul style="list-style-type: none"> • 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. <p>Moving expenses include the packing and moving of belongings.</p> <p><i>Prior authorization required. See details on page 75.</i></p>
<p>Nursing facility services – both intermediate and skilled nursing</p>	<p>Covered for members who need 24-hour-a-day help with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). These members need regular, long-term care from licensed nurses and paramedical personnel. Long-term services require Med-QUEST Division approval. Care is provided in a nursing facility that includes:</p> <ul style="list-style-type: none"> • 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. <p><i>May require prior authorization. See details on page 76.</i></p>



Medical Health Services	Coverage and Limits
<p>Other practitioner services</p>	<p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Certified nurse midwife services. • Licensed advanced practice registered nurse (APRN) 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.
<p>Out-of-state and off-island coverage</p>	<p>We provide any medically necessary covered services that are prearranged when not available on your island or in Hawaii. This includes:</p> <ul style="list-style-type: none"> • 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). <p><i>May require prior authorization. See details on page 75.</i></p>
<p>Outpatient hospital care</p>	<p>This service includes 24/7 care for:</p> <ul style="list-style-type: none"> • 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. <p><i>May require prior authorization. See details on page 75.</i></p>



Medical Health Services	Coverage and Limits
<p>Outpatient hospital procedures</p>	<p>Covered services include:</p> <ul style="list-style-type: none"> • Sleep laboratory services. • Surgeries performed in a free-standing ambulatory surgery center (ASC) and in a hospital ASC. <p><i>May require prior authorization. See details on page 75.</i></p>
<p>Palliative Care</p>	<p><i>Palliative care</i> is special care for people who have serious illnesses. This care helps ease symptoms and stress caused by the illness. The goal is to make life better for both the person and their family. It can be given to anyone, no matter how old they are, and be provided alongside treatments aimed at curing the illness.</p> <p>This care focuses on the needs of both the patient and their family. It helps improve quality of life. It prevents and treats pain and other problems. It takes care of the person’s physical needs, emotional needs, social needs, and spiritual needs.</p> <p><i>May require prior authorization. See details on page 75.</i></p>
<p>Personal assistance services level 1</p>	<p>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 to keep them in their home.</p> <p>Services may include:</p> <ul style="list-style-type: none"> • Meal preparation. • Laundry. • Shopping. • Errands. • Light housekeeping tasks. <p><i>Prior authorization required. See details on page 75.</i></p>



Medical Health Services	Coverage and Limits
<p>Personal assistance services level 2</p>	<p>Covered for those who need help with daily activities and keeping up their health. This level of service is provided by a home health aide (HHA), personal care aide (PCA), certified nurse aide (CNA), or nurse aide (NA) with applicable skills. Some activities include:</p> <ul style="list-style-type: none">• 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. <p><i>Prior authorization required. See details on page 75.</i></p>



Medical Health Services	Coverage and Limits
<p>Personal emergency response systems (PERS)</p>	<p>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.</p> <p>PERS services are limited to those individuals who:</p> <ul style="list-style-type: none"> • Live alone or are alone for significant parts of the day. • Have no regular caregiver for extended periods. • Would otherwise need extensive routine supervision. • Live in a non-licensed setting, except an assisted living facility. <p><i>Prior authorization required. See details on page 75.</i></p>
<p>Physician services</p>	<p>Services must be medically necessary and provided at a:</p> <ul style="list-style-type: none"> • Physicians' offices. • Clinic. • Private home. • Licensed hospital. • Licensed skilled nursing facility. • Intermediate care facility. • Licensed or certified residential setting.



Medical Health Services	Coverage and Limits
Podiatry services	<p>Covered services include:</p> <ul style="list-style-type: none">• Professional services, not involving surgery, provided in an office or clinic.• Professional services, not involving surgery, related to diabetic foot care and provided in an outpatient or 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 an injury that is given 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	<p>Post-stabilization services, inpatient and outpatient, are covered at all times when 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.</p>
Prescription drugs	<p>Covers drugs listed on our preferred drug list (PDL). This list also has drugs that may have limits such as prior authorization, quantity limits, step therapy, age limits, or gender limits. Alternative drugs may be covered with prior authorization.</p>



Medical Health Services	Coverage and Limits
<p>Preventive services</p>	<p>Services include but are not limited to:</p> <ul style="list-style-type: none"> • Initial and interval histories. • Comprehensive physical examinations (including developmental services). • Immunizations. • Family planning. • Diagnostic and screening laboratory. • X-ray services (including screening for tuberculosis). <p><i>May require prior authorization. See details on page 75.</i></p>
<p>Private-duty nursing</p>	<p>Covered for those who need ongoing nursing care. Service is provided by licensed nurses within the scope of state law.</p> <p><i>Prior authorization required. See details on page 75.</i></p>
<p>Radiology, laboratory, and other diagnostic services</p>	<p>Covered services include:</p> <ul style="list-style-type: none"> • Diagnostic. • Therapeutic radiology and imaging. • Screening and diagnostic laboratory tests. <p><i>May require prior authorization. See details on page 75.</i></p>



Medical Health Services	Coverage and Limits
Reentry services	Reentry services support eligible members as they prepare to leave incarceration and transition back to the community, beginning up to 90 days before release or shortly after release, if needed, with extra protections for some eligible juveniles. Services include case management and transition planning, medication for addiction treatment, a 30-day supply of medications at release, clinical visits, dental screening and diagnostic services, medical equipment, and peer support. These services are designed to promote continuity of care, recovery, and a successful return to the community.
Rehabilitation services	Covered services include: <ul style="list-style-type: none">• Physical and occupational therapy.• Audiology and speech / language therapy. <i>May require prior authorization. See details on page 75.</i>
Respite care	Respite care is short-term based care that 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): <ul style="list-style-type: none">• 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. <i>Prior authorization required. See details on page 75.</i>
Smoking cessation	Smoking cessation means quitting tobacco or cigarettes. Covered services include: <ul style="list-style-type: none">• Medication to help quit.• Counseling to help quit.• Two quit attempts per benefit period.



Medical Health Services	Coverage and Limits
<p>Specialized medical equipment warranty and supplies</p>	<p>Refers to the purchase, rental, lease, warranty, and supplies costs, installation, repairs, and removal of devices, controls, or appliances that the member was already approved for and that was specified in the care plan. This also includes:</p> <ul style="list-style-type: none"> • 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. <p>Examples include:</p> <ul style="list-style-type: none"> • Specialized infant car seats. • Modification of a 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. <p><i>Prior authorization required. See details on page 75.</i></p>
<p>Sterilizations</p>	<p>Covered if:</p> <ul style="list-style-type: none"> • 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. <p><i>May require prior authorization. See details on page 75.</i></p>



Medical Health Services	Coverage and Limits
<p>Telehealth services</p>	<p>Services may include, but are not limited to:</p> <ul style="list-style-type: none"> • 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. <p>Services not covered include:</p> <ul style="list-style-type: none"> • Standard phone calls, faxes, or email (in combination or individually). • Getting medication by filling out an online form. <p>If you get in-person care that needs prior approval, you need prior approval to get the same care through telehealth.</p> <p>Providers will tell you if they provide telehealth services. Your provider bills the plan for these services.</p>
<p>Transplant services</p>	<p>Cornea transplants and bone grafts are covered. Other transplants are covered under the State of Hawaii Organ and Tissue Transplant Program, not the QUEST (Medicaid) program.</p> <p><i>May require prior authorization. See details on page 75.</i></p>
<p>Transportation services</p>	<p>The plan provides emergency and non-emergency ground and air services to and from medically necessary medical appointments for members who:</p> <ul style="list-style-type: none"> • 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. <p>Transportation is not provided to day programs that are not medically necessary.</p> <p><i>To learn more about transportation, see page 70.</i></p> <p><i>May require prior authorization. See details on page 75.</i></p>



Medical Health Services	Coverage and Limits
<p>Urgent care services</p>	<p>Covered as medically necessary. <i>May require prior authorization. See details on page 75.</i></p>
<p>Vision services</p>	<p>We provide eye and vision services for members.</p> <ul style="list-style-type: none"> • For members under age 21: One routine eye exam every 12 months. • For members ages 21 and older: One routine eye exam every 24 months. <p>More visits and services may be allowed, depending on the symptoms or medical condition. Prior authorization is needed.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Vision exams. • Cataract removal. • Ophthalmologic exam with refraction. • Prescription lens. • Prosthetic eyes. • Visual aids once every 24 months. • Cornea (keratoplasty) transplants. <p>New lenses if medically necessary:</p> <ul style="list-style-type: none"> • Once every 24 months. <p>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.</p> <p>Premier provides this care for you. Call ‘Ohana Customer Service to:</p> <ul style="list-style-type: none"> • Find a provider. • Make an appointment.



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, call us toll-free at **1-888-846-4262** (TTY: **711**).

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

We understand the importance of education, which is why we offer this program. If you are age 18 or older, don't have your high school diploma, and are not currently enrolled or attending high school, you can take the GED® or HiSET® tests at no charge. Visit **ohanahealthplan.com** to learn more and to 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.

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.

Note: On January 1, 2026, you will have a new way to get over-the-counter (OTC) products through our partnership with CVS. There are three easy ways to get your OTC items each month:

In Store	Online	By Phone
<ul style="list-style-type: none"> • Visit your nearest CVS store. • Find approved items through your plan's catalog. • Look for blue labels that have the OTC indicator and SKU number. • Go to any register to check out. • For a faster checkout, use the mobile app to show the cashier a digital barcode. 	<ul style="list-style-type: none"> • Go to cv.com/benefits and sign in or create an account. • Select "Shop OTC benefits." Your benefit amount and balance will show. • Search and add items to your basket. When you are ready to place your order, select "Checkout." • Confirm the shipping information and select "Place Order." 	<ul style="list-style-type: none"> • Orders can be placed by calling 1-888-262-6298. • Agents are available Monday through Friday, from 9 a.m. to 8 p.m., local time. • Please have your order ready before you call. • Orders can be placed through the phone system using the item or UPC number.



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 services for qualified members with asthma.
 - Two carpet cleanings per plan year.
- HEPA filter vacuum cleaner:
 - Provides qualified members with asthma with a vacuum cleaner with a high efficiency particulate air (HEPA) filter, which traps pollutants and may help bring allergy relief.
 - Limit of one vacuum cleaner per member/per household.
- 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. 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.

WW (formerly WeightWatchers®)

‘Ohana offers a six-month program to support healthy lifestyles and improve health outcomes. Available for members 18 and up when requirements are met. Members should be referred by their provider. WW is available online, in-person, or a mix of the two.

Case management or disease management approval is required. Available to members ages 18 years or older with a BMI equal or greater than 25.

Pain management program

This program helps qualified members manage chronic pain. Prior authorization is needed if criteria is met. 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 tissues, tendons, and ligaments) to help manage pain.



- **Chiropractic therapy** is the manipulation of the spine by a licensed chiropractor to treat pain.
- **Biofeedback** is a chronic pain management technique in which an underlying disease has been ruled out or treated.

Caregiver package

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

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

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.

Assurance Wireless phone program

‘Ohana has a new program that gives phones to members who lack secure and reliable access to smartphones, along with a phone plan. Those who qualify for the Lifeline program will get unlimited texts and talk, and 10 gigabytes (GB) of high-speed data.

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 ‘Ohana 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
Kailua Kona	Kealahou	1-808-491-9226
Kauai	Lihue	1-808-274-3883
Maui		
Wailuku	Wailuku	1-808-243-1252
Molokai	Kaunakakai	1-808-553-7878

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**.

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 plan health coordinator to get a referral to CCS.

Development disability waiver program

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

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

Contact the 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.
- **1-808-243-4625** in Wailuku, Maui.
- **1-808-241-3406** in Lihue, Kauai.
- **1-808-974-4280** in Hilo, Hawaii.



Dental

Dental services are 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 Neighbor Islands to Oahu.

Some limitations may apply. Prior authorization may be needed. Covered services include:

Services	Description and Limitations
Preventative services	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Bitewing X-rays: two per year. • Full series X-rays: one every five years. • Periapical X-rays. • Biopsies of oral tissue.
Endodontic therapy services	<ul style="list-style-type: none"> • Root canal therapy on permanent molars.
Restorative services	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Scaling and root planning: one every 24 months.
Prosthodontic services	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 'Ohana. 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 toll-free at **1-800-235-5477** (on Oahu, call **1-808-594-0066**).
- Department of Education (DOE) school-based services: Call **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.

'Ohana 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 before you get the service.

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	<p>Not covered when:</p> <ul style="list-style-type: none"> • 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, and other diagnostic services	<p>Non-covered services include:</p> <ul style="list-style-type: none"> • Ultrasounds for gender determination. <p>Laboratory and diagnostic services:</p> <ul style="list-style-type: none"> • Experimental. • Investigational or generally unproven. • IgG4 testing. • Procedures related to storing, preparing, and transferring oocytes for <i>in vitro</i> fertilization.
Vision services	<p>Non-covered services include:</p> <ul style="list-style-type: none"> • 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?

We recommend going to a participating ‘Ohana provider, but you can get a valid prescription from any active and licensed prescriber who is not on the Office of Inspector General (OIG) exclusion list.



Which pharmacies can fill my prescription?

Prescriptions must be filled at a pharmacy in our network. The provider directory lists these pharmacies and can be downloaded from our website or searched online at **findaprovider.ohanahealthplan.com**. You may also be able to get your prescriptions through mail order / home delivery. Call Customer Service to learn more.

What is the process for getting a prescription filled?

Bring all of your insurance ID cards to the pharmacy (e.g. QUEST [Medicaid], Medicare, CCS, etc.). There should be no copays for drugs covered by QUEST (Medicaid). You may be responsible for copays for drugs covered by other insurance, like Medicare Part D.

Preferred Drug List

What medicines does 'Ohana QUEST (Medicaid) pay for?

'Ohana pays for medicines listed on our formulary, or preferred drug list (PDL). Providers and pharmacists decide which drugs should be on this list.

Some drugs require approval from 'Ohana first. You, your provider, or an appointed representative can ask us for approval. This applies to drugs that need prior authorization or step therapy, have quantity or age limits, and drugs not listed on the formulary.

You can view or download a copy of the PDL at **ohanahealthplan.com/providers/medicaid/pharmacy.html**.

You can also call Customer Service if you would like a printed PDL mailed to you.

What medicines does QUEST (Medicaid) not cover?

Your QUEST (Medicaid) benefit does not include:

- Drugs used for pulmonary tuberculosis (TB). Instead, this medicine is provided free from Lanakila Health Center or Leahi Hospital on Oahu, or from local health department TB clinics on Neighbor Islands.
- Drugs used for Hansen's disease (leprosy). Instead, this medicine is provided free from the Department of Health's Hansen's Disease Program.
- "Less Than Effective" (LTE) Drug Efficacy Study Implementation (DESI) Drugs.
- Medical foods and food supplements.
- Drugs used for cosmetic purposes or to help you grow hair.
- Drugs to help you get pregnant.
- Travel vaccines.
- Vaccines for children up to 18 years old. Routine vaccines are provided free from the Vaccines for Children (VFC) Program through your child's doctor.
- Drugs used for eating problems, weight loss, or weight gain.
- Drugs used for erectile dysfunction.
- Investigational or experimental drugs.
- Drugs used for any purpose that is not medically accepted.



Can I get any medicine I want?

‘Ohana will cover all medicines that are medically necessary for you. Some drugs require approval from ‘Ohana first. You, your provider, or an appointed representative can ask us for approval. This applies to drugs that need prior authorization or step therapy, have quantity or age limits, and drugs not listed on the formulary. 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 the drug you asked for if you do not try the preferred drug first.

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 the brand name drugs.

Other Drugs You Can Get at the Pharmacy

Does ‘Ohana cover OTC drugs?

Yes, ‘Ohana QUEST (Medicaid) covers OTC drugs that are listed on the PDL. Your pharmacy will need a prescription from your provider for these to be covered with no copay.

Pharmacy Lock-In

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 to protect you from potentially dangerous drug interactions.

The ‘Ohana Pharmacy Lock-In Program can 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 ‘Ohana Pharmacy Lock-In Program, you can file an appeal with us. See the *Member Grievance and Appeals Procedures* section in this handbook for more information.

If your assigned pharmacy does not immediately have your medication, you’ll be able to get a 72-hour emergency supply at another pharmacy as long as your provider is in our network.

There is no cost for the ‘Ohana Pharmacy Lock-In Program. It is a voluntary service. For questions or to begin working with a care team, please call us toll-free at **1-888-846-4262** (TTY: **711**).

Pharmacy Direct Member Reimbursement (DMR)

What is a DMR?

Sometimes you may pay for medications out of pocket at a pharmacy. This can happen if you forget to show your insurance ID card(s). After such a purchase, you have 12 months to send us a claim form



and receipts to recover your costs. This is called 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**.

Where do I send my DMR request?



Send the form to:

Centene Pharmacy Services
7625 N. Palm Ave., Suite 107,
Fresno, CA 93711



Fax: **(844) 678-5767**



Email: **claimsprocessing@centene.com**

What do I need to include with each reimbursement request?

- A completed, signed Member Pharmacy Reimbursement Claim Form.
- A detailed prescription receipt (handwritten receipts are not accepted) or pharmacy printout with the following information:
 - The member's name.
 - The pharmacy name.
 - The prescriber's name.
 - The drug name.
 - The drug strength.
 - The quantity dispensed.
 - The number of days supplied.
 - 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. If needed, you can send in your request again with the missing information.

How much will I get back?

If approved, we will mail you a check for the plan-contracted price, which may not be the retail price.

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

Processing can take up to 30 days from the date we get your Member Pharmacy Reimbursement Claim Form. Be sure your form is complete with all the needed information. Otherwise, your request may be delayed or denied. Formulary guidelines apply to all pharmacy reimbursement requests.

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

If you do not like the decision we make, you have the right to appeal it. See the *Member Grievances and Appeals 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 telehealth services, call us toll-free at **1-888-846-4262** (TTY: **711**) or visit <https://www.ohanahealthplan.com/members/medicaid/quest-medicaid/telehealth.html>.

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.
- Live 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 include:

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

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

Bus service will be used if:

- Your physical condition allows it (you are able to walk on your own or use a wheelchair).
- You live less than a half mile from a bus stop.
- Your destination is no more than a half mile from a bus stop.

Taxi service will be used if:

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



- You live more than a half mile from a bus stop.
- Your destination is more than a half mile from a bus stop.

TheHandi-Van service will be used if:

- You live on Oahu.
- Your physical condition does not allow you to ride the bus.
- You are certified for this service.

You must be certified to ride TheHandi-Van. TheHandi-Van Eligibility Center is located 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 to set up an in-person interview.

Questions?

If your provider says you are unable to ride the bus or TheHandi-Van, or if you have neither service in your area, we will work with you to find another way to get you where you need to go. Be sure to talk with your provider about any ongoing appointments. They can request NET for you as well.

Three steps for using your transportation benefit

- 1** Schedule a ride by calling Transdev Health Solutions toll-free at **1-866-790-8858**. 'Ohana 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 Transdev Health Solutions 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.

If you are not sure when you will be finished with your appointment, please call the Transportation Help Line toll-free at **1-866-481-9699** after your appointment. NET services will arrive within 60 minutes. Please allow for this time. Let them know exactly where to pick you up. This will help the driver find you.

If you have a grievance about NET, please call 'Ohana Customer Service or Transdev Health Solutions toll-free at **1-866-481-9699** and tell us about your experience.

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.



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 personal treatment plans, establish treatment goals, monitor outcomes, and evaluate for possible care plan revisions. 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 with a health coordinator who best meets your needs. They will then 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 toll-free at **1-888-846-4262** (TTY: **711**). You can also send a written request or a message through the secure online member portal.

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 any time, even after business hours, on holidays, or on weekends. A nurse will try to answer your questions by phone 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.

To learn more, please call Customer Service toll-free at **1-888-846-4262** (TTY: **711**) and ask for the health coordination team.



Disease Management

‘Ohana has disease management programs to help you better understand and manage your chronic health condition. The goals of these 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.
- Asthma.
- High blood pressure (*hypertension*).
- Quitting smoking (referral to the Hawaii Tobacco Quit Line).
- Heart failure.

Any member with these conditions may join this program at no cost. Your health coordinator or provider may refer you to a 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 is happy to help. You do not need prior approval from your PCP. We will give you the names of behavioral health providers near you. You may choose from these names to set up an appointment.

What to do if you are having a problem

We can help you find a behavioral health provider. Call us if you have any of these problems.

- Always feeling sad.
- Feeling hopeless and/or helpless.
- Feeling guilty and/or worthless.
- Having difficulty sleeping or sleeping too much.
- Poor appetite.
- Unexplained weight loss or weight gain.
- Loss of interest in activities.
- Difficulty concentrating.
- Irritability.
- Constant pain such as headaches, stomachaches, and backaches.



You can see any in-network behavioral health provider without a referral from your PCP 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. If you feel that you may be a danger to yourself or others, 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 a specialist will ask for prior authorization.

Call Customer Service, check your provider directory, or visit our website for a list of emergency and post-stabilization service settings in our network.

Other ‘Ohana Programs

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

- Programs to stop smoking.
- Drug and alcohol programs.
- Domestic abuse support.
- Programs for pregnant individuals 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. A 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

You do not need approval from your PCP or the plan for these services. Please see the *Covered Services* section for more details. 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 under the age of 21.
- Lab tests.
- Basic X-rays.
- Routine vision services.
- Routine behavioral health outpatient services.
- Disease management.

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

You can find a list of providers at findaprovider.ohanahealthplan.com. You can also call Customer Service to ask for a printed 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 us to arrange care for you. Prior authorization may be needed.

Services that require prior authorization/precertification

Sometimes we need to approve 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, ‘Ohana 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.

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

‘Ohana is committed to responding to standard requests for prior authorization within seven (7) calendar days. An extension may be granted for up to fourteen (14) extra calendar days if you or your provider requests an extension, or if we justify a need for more information and the extension is in your best interest. We will notify you and your provider in writing of the reason for the extension and your rights to file a grievance if you disagree with our decision.

If the provider indicates, or if ‘Ohana determines, that the standard time frame could seriously jeopardize your life or health, ‘Ohana will make an expedited (fast) authorization decision within 72 hours of the request. For continued care (concurrent) reviews, we will give you a decision within 72 hours of the request.

Utilization management program

We have a utilization management (UM) program. It 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. Our UM program includes:

- **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 when you leave a hospital by making sure that you have 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 want to make sure the services you get match your ‘Ohana health plan coverage. We also check to see if the care and services are provided at the right place and at the right time. Then, we decide how much coverage we can provide according to your benefits. We also decide on how to pay those who give you the care.

There may be times when we say we cannot cover services or care that your provider requests. This may be due to benefit limitations or lack of medical necessity. These decisions may be made by our licensed clinical staff. They are nurses, doctors, and licensed behavioral health clinicians.

We make sure our reviews are based only on the suitability of care and your benefit coverage. We do not give 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 got that we determine were not medically necessary.



If ‘Ohana objects to providing a service on moral or religious grounds, we will let you know 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 any services you get.

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 tell you 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 to learn more.

Emergency services

Emergency services are for serious conditions that must be treated right away. This may include inpatient or outpatient services, or medical facility services and treatment. (See the ‘Ohana glossary for a definition). We will give you the names of providers near you. Call Customer Service, check your provider directory, or visit our website for a list of emergency and post-stabilization service settings near you.

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	Kealahou	HI	96750	Hawaii	1-808-322-9311



Facility Name	Address	City	State	ZIP Code	Island	Phone Number
Queens North Hawaii Community Hospital	67-1125 Mamalahoa Hwy	Kamuela	HI	96743	Hawaii	1-808-885-4444
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



Facility Name	Address	City	State	ZIP Code	Island	Phone Number
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 toll-free at **1-888-846-4262** (TTY: **711**), 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 street address, city, county, or ZIP Code and click “Select your plan.”
- 3** Select a network from the drop-down menu. Choose either:
 - a.** ‘Ohana Community Care Services (CCS).
 - b.** ‘Ohana QUEST (Medicaid).
- 4** Click “Continue.”
- 5** Select how you want to search:
 - a.** Search by specialty, facility / group name, provider name, or NPI. For example, you can type in “social worker” to look for providers in that specialty or you can enter a specific provider’s name. When you have entered the needed information, click “Search.”
 - b.** Search using the category search tiles. Click on one of the boxes for:
 - i.** Medical professionals.
 - ii.** Medical facilities.
 - iii.** Behavioral health.
 - iv.** Pharmacy & medical supplies.
 - v.** Vision.
 - c.** From the right side of the screen, click any of our popular searches links:
 - i.** Primary care.
 - ii.** Clinic or urgent care.
 - iii.** Pediatrics (babies, children).
 - iv.** Dental professionals.



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.
- Can't breathe.
- Broken bones.

An emergency is when a lack of immediate attention could result in:

- 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 'Ohana 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 (called *post-stabilization care*).

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 get.

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 visit. This is called post-stabilization care. This care is needed to maintain, improve, or solve your medical condition.

If you have questions or are unsure about your care, call the provider that treated you while you were in the hospital. If the provider's office is closed, 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. You do not need prior authorization for this. However, this care must be needed 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 you get while you are out of the service area, write to our Claims Department. They need copies of your medical reports and the bills. They also need proof of payment. You have up to one year from the date of service to ask to be paid back (called *reimbursement*).



If you get sick or hurt while outside of the ‘Ohana 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. Some examples of urgent care conditions are:

- Injury.
- Illness.
- Severe pain.

If you aren't sure if you need urgent care, call your PCP or our 24-hour Nurse Advice Line. Urgent care services may need prior approval. You must show your ‘Ohana 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 decide 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 will work with you to try to get the service locally. We will decide within seven (7) calendar 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. Sometimes we will need more time to make a fast decision. This can mean up to 14 more 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 ‘Ohana 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

If you are pregnant, you should visit an ‘Ohana obstetrics (OB) provider within 14 days of joining 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* (before birth) 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 60 days after giving birth. 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 will be assigned to 'Ohana.

Transition of Care

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

If you are leaving 'Ohana, we can help with your transition. Please call Customer Service to help you get the care you need.

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

'Ohana has an EPSDT program that provides needed care for members under the age of 21. EPSDT may include services like:

- Preventive care for members from newborn through age 20.
- Services.
- Lab tests (as needed).
- Prescriptions (as needed).
- A comprehensive history and physical exam.
- Behavioral and mental health assessments.
- Growth and development charts.
- Vision, hearing, and language screenings.
- Nutritional health and education.
- Lead risk assessment and testing, as appropriate.
- Age-appropriate vaccines (immunizations).
- Dental screening and referrals to a dentist.
- Referrals 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 American Academy of Pediatrics 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 guidelines to help you know when it is time to visit your PCP. The guidelines 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 up 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 about other needed services based on you or your child's healthcare needs. Always talk with your PCP. Be sure to tell them about any 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?CDC_AAref_Val=https://www.cdc.gov/vaccines/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 joining our plan. Pregnant members should be seen in the first 14 days of enrollment.

The following resources include recommendations published by the U.S. Preventive Services Task Force (USPSTF) and the Centers for Disease Control and Prevention.^{1,2}

- Recommendations for Adult Preventive Health Care:
<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations>
- Recommended Adult Immunization Schedule for Persons aged 19 years or older:
www.cdc.gov/vaccines/hcp/imz-schedules/downloads/adult/adult-combined-schedule.pdf



References

¹ U.S. Preventive Services Task Force (USPSTF). *A&B 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 directive?

You can call a lawyer or your local legal aid office. You can also ask your provider or call Customer Service 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 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 in your medical record. Give one to a trusted family member or friend. Keep a copy with your personal papers. You should also send a copy to 'Ohana. We will make sure it is 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 people 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 directive?

Yes, as long as your advance directive 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 get. 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 also has rules for filing grievances 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 any time by calling or writing to us. Your provider or someone else you choose can also file a grievance for you if you give them permission to do so. To give permission, you must send us a note in writing.

Within five business days of getting your grievance, we will mail you a letter telling you that we got your grievance. We will make a decision within 30 calendar days of getting the grievance.

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

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

The plan must explain the delay to the member:

- Orally by close of business on the day the decision is made to extend the time frame.
- In writing within two calendar days of the decision to extend.

We will work to 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 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 filing your grievance.



State Grievance Review

You can also ask for a state grievance review. This must be done within 30 calendar days from the date on the grievance resolution 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 these actions occur:

- If we deny or limit a service you or your provider asked 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 got.
- If we fail to give services in the required time frame.
- If we fail to give you a decision on an appeal you already filed in the required time frame.
- If we fail to give you a resolution on a grievance in the required time frame.
- If we do not agree to let you see a 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 your 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. You can file by calling or writing to us. We can help you file your appeal if needed.

You can also get help from others to file an appeal. Your provider or someone else you choose can help file an appeal if you give them your written permission. They can also discuss your appeal with us on your behalf. 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	
<p>For appeal requests for medical services:</p> <p>‘Ohana Health Plan Attn: Appeals Department P.O. Box 31368 Tampa, FL 33631-3368</p>	<p>For appeal requests for pharmacy medications:</p> <p>‘Ohana Health Plan Attn: Pharmacy Medication Appeals Department P.O. Box 31398 Tampa, FL 33631-3398</p>
<p>Fax to: 1-866-201-0657</p>	<p>Fax to: 1-888-865-6531</p>

We will send you a letter within five business days of getting your appeal. This letter will let you know we got it. We will then review your appeal 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 your appeal file. You can review all documents and records received and any new or additional information considered and/or relied upon. You can look at all of the information we used to make the decision during or before the appeal decision is made, as well as after the review of the appeal. You can ask for this information free of charge.

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 also 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 a written notice.
- Tell 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 (fast) appeal is limited due to the short processing time frame. You also may review your appeal file any time during or after the review of your appeal.



Can an appeal be extended?

You can ask us for up to 14 more days to give us more information for standard and fast appeals. We may also ask for 14 more days if we feel more information is needed and it is in your best interest. If we ask for the extra days, we will try to give you oral notice of the extension and will send you a written notice within two days. The notice will tell you when the review will be completed. It will also tell you that you have the right to file a grievance if you disagree with the extension.

What if I do not like an appeal decision?

You may not like the appeal decision we make. If so, you can ask for a State Administrative Hearing. Someone you choose to act for you can also ask for one. You must do this within 120 calendar days of getting the appeal decision letter. The letter will tell you how to file for a State Administrative Hearing with the Administrative Appeals office. You can only ask for a State Administrative Hearing after you have completed our 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.

You also have the right to ask for an expedited (fast) State Administrative Hearing. You may only do this when you asked for, or 'Ohana QUEST (Medicaid) provided, a fast appeal review. You or your representative can ask for the hearing if we denied the fast appeal. You must do this within 120 calendar days of the final appeal determination. The letter will tell you how to file an appeal. To do so, send your request to the address above. The State will make a decision within three business days from when they get your request.

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 got your Notice of Adverse Benefit Determination .
- 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; 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.
- 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.

If the plan or the State changes the decision to deny, limit, or delay services that were not provided while the appeal or State Administrative Hearing was pending, the plan shall authorize or provide the service promptly and as fast as your health requires, but no later than 72 hours from when the ruling reversing the determination is received.



Important Member Information



Enrollment Information

Enrollment

If you did not choose a health plan, the MQD chose 'Ohana 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 get 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 required information.

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

Here are some items you may need when you recertify:

- 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 quickly. If you don't, your benefits could end. If you have questions about recertifying your Medicaid eligibility, call us 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.

You can also 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

'Ohana Health Plan is dedicated to helping you get the most out of your health insurance. Our health coordinators and Customer Service representatives can help you get the care you need. Anytime you need help, just 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.

'Ohana 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 be 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, please call Customer Service.

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)

Direct member reimbursement 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 reimbursement claim form and receipts to recover your costs.

To get a copy of the member 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 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 call Customer Service toll-free at **1-888-846-4262** (TTY: **711**) if your reimbursement request is for hearing, transportation, or vision services.

FOLLOW THESE INSTRUCTIONS CAREFULLY. For the reimbursement of medical services, you need to:



Complete the member 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 Include all the following information:

- Date of each service.
- Location of each service, such as a doctor's office, independent laboratory, outpatient hospital, inpatient hospital, or the patient's home.
- Description of each surgical or medical service or supply furnished.
- Charge for each service.
- The doctor or supplier's name and address. A bill will often 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 Provide proof of payment, such as:

- Copy of canceled check (front and back).
- Credit card statement showing provider as paid.
- Invoice / statement from doctor or provider showing their 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.

We review the findings to:

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

We review new technology in these areas:

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

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

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. Call Customer Service toll-free at **1-888-846-4262** (TTY: **711**) to get more information or a copy of the newsletter.



Fraud, Waste and Abuse

Billions of dollars are lost to healthcare fraud every year. What is 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 getting payment for services that were not performed.

Here are some 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.
- Getting medications and then selling them to someone else.
- Asking for and getting transportation services to go somewhere other than to a medical appointment.

Tell us if you think or know that fraud, waste, or abuse has occurred. We will determine if something is fraud, waste, or abuse. Call our 24-hour Fraud Hotline at **1-866-685-8664** (TTY: **711**). It is private. You may leave a message without leaving your name. We will call you back if you leave your phone number. We do this to be sure our information is complete and accurate. You can also report fraud on our website. This is private to. Go to <https://www.ohanahealthplan.com/members/medicaid/quest-medicare/member-rights-policies/fraud-and-abuse.html>.

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. This rule is called the Interoperability and Patient Access rule (CMS-9115-F) and makes it easier to get your health records when you need it most.

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: <https://www.ohanahealthplan.com/members/medicaid/quest-medicaid/benefits/interoperability-and-patient-access.html>.

Member Rights and Responsibilities

Member Rights

As an 'Ohana member, you have the right:

- To get information about the plan, its services, its practitioners, and its providers.
- To get 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.
- To get care that meets the requirements for timely access and medically necessary coordinated care (42CFR438.206 through 42CRF438.210).
- To make your healthcare wishes known by using advance directives.
- To have input in the plan's member rights and responsibilities.
- To use these rights no matter your sex, age, race, ethnicity, income, education, or religion.
- To have all plan employees honor your rights.
- To get healthcare services that are accessible and comparable in amount, duration, and scope to those provided under Medicaid Fee-for-Service (FFS) and are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- To get all information in a way that you can easily understand, in alternative formats and in a manner that takes into consideration your special needs.
- To get help in understanding the rules and benefits of the plan.
- To get verbal interpretation services at no cost. This is for all non-English languages, not just those that are most common.
- To be told that verbal interpretation is available to you — and how to get this service.
- To get information about:
 - The basic features of managed care.
 - Who may or may not join the program.
 - The plan's responsibilities for coordination of care in a timely manner in order to make an informed choice (potential members).
- To get a complete description of your right to leave the plan at least once a year.
- To get 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 get a second opinion at no cost to you.
- To get 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 get services according to the appointment waiting time standards.
- To get services in a culturally competent manner.
- To get services in a coordinated manner.
- To have your privacy protected.
- To be included in service and care plan development.
- To have direct access to specialists (if you have a special healthcare need).
- To not have services arbitrarily denied or reduced in amount, duration, or scope solely because of diagnosis, type of illness, or condition.
- To receive a description of cost sharing responsibilities, if any.
- To not be held liable for:
 - The health plan's debts in the event of insolvency.
 - The covered services provided to you by the health plan for which the DHS does not pay the health plan.
 - Covered services provided to you for which the DHS or the health plan does not pay the healthcare provider that furnishes the services; and payments of covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount you would owe if the health plan provided the services directly.
 - Only be responsible for cost-sharing as described by your plan in accordance with 42 CFR Section 447.50 through 447.57.

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

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



Member Responsibilities

You also have responsibilities as a member:

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

