HAWAIʻI
MEMBER HANDBOOK
QUEST INTEGRATION

OHANA™
Health Plan
‘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 Integration Medicaid members. Many people now get their health benefits through managed care. Managed care plans like ‘Ohana are contracted by the Department of Human Services to help provide quality, cost-effective healthcare. We work with doctors, specialists, hospitals, labs and other healthcare facilities that are a part of our network to provide the benefits offered by Medicaid and to coordinate your healthcare needs. As a member, you may select a primary care provider (PCP). Your PCP will be your personal doctor. He or she 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 25).

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 will tell you more about your benefits and how your health plan works. Please read it and keep it in a safe place. We hope it will answer most of your questions.

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

We wish you good health!
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WE’RE HERE TO HELP
WE’RE HERE TO HELP

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

Help from ‘Ohana Customer Service

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

- Benefits
- Replacing a lost ID card
- Filing a grievance
- Changing your doctor
- Getting a list of doctors and drug stores 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
949 Kamokila Boulevard
3rd Floor, Suite 350
Kapolei, HI 96707

@OhanaHealthPlan
www.facebook.com/OhanaHealthPlan
We Protect Your Privacy!

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

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

### Other ‘Ohana Offices

<table>
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<th>‘Ohana Health Plan – Regional Sales Office</th>
<th>‘Ohana Health Plan – Maui Office</th>
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<tbody>
<tr>
<td>500 Ala Moana Boulevard</td>
<td>285 West Ka‘ahumanu Avenue</td>
<td>194 Kilauea Avenue</td>
</tr>
<tr>
<td>1 Waterfront Plaza, Suite 1D</td>
<td>Suite 101B</td>
<td>Suites 102 and 103</td>
</tr>
<tr>
<td>Honolulu, HI 96813</td>
<td>Kahului, HI 96732</td>
<td>Hilo, HI 96720</td>
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### Our Service Area

‘Ohana serves the following areas:

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

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

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

Important Phone Numbers

<table>
<thead>
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<th>Contact Name</th>
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<td>Customer Service</td>
<td>1-888-846-4262 (TTY 711)</td>
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<tr>
<td>24-Hour Nurse Advice Line</td>
<td>1-800-919-8807</td>
</tr>
<tr>
<td>Transportation Requests (IntelliRide)</td>
<td>1-866-790-8858</td>
</tr>
<tr>
<td>Transportation Ride Assist Line (IntelliRide)</td>
<td>1-866-481-9699</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>1-888-846-4262 (TTY 711)</td>
</tr>
<tr>
<td>Dental – Community Case Management Corporation (CCMC)</td>
<td>1-888-792-1070</td>
</tr>
<tr>
<td>Vision (Premier)</td>
<td>1-888-846-4262 (TTY 711)</td>
</tr>
<tr>
<td>Hearing (HearUSA)</td>
<td>1-888-846-4262 (TTY 711)</td>
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<tr>
<td>Pharmacy</td>
<td>1-888-846-4262 (TTY 711)</td>
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<tr>
<td>Hawai’i Med-QUEST Division</td>
<td>1-800-316-8005</td>
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Sign Into Your Secure Member Portal on Our Website

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

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

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

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

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

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

The Ombudsman program is available to all members. You can learn more by contacting the Hilopa‘a Family to Family Health Information Center. You can visit their website at www.hilopaa.org. You can also call, email or fax them using the contact information below:

<table>
<thead>
<tr>
<th>Island</th>
<th>Phone Number</th>
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<tr>
<td>O‘ahu</td>
<td>808-791-3467</td>
</tr>
<tr>
<td>Hawai‘i</td>
<td>808-333-3053</td>
</tr>
<tr>
<td>Maui and Lana‘i</td>
<td>808-270-1536</td>
</tr>
<tr>
<td>Moloka‘i</td>
<td>808-660-0063</td>
</tr>
<tr>
<td>Kaua‘i</td>
<td>808-240-0485</td>
</tr>
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</table>

Email: advocate@hilopaa.org

O‘ahu fax: 1-808-531-3595
THE ‘OHANA GLOSSARY

WORDS/PHRASES

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

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

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

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

“At-Risk” Services: Some members living at home might need “at-risk” services to prevent them from worsening.

Authorized Representative: An individual or organization designated by the member, in writing, with the designee’s signature or by legal documentation of authority to act on behalf of a member, in compliance with federal and state law regulations. Designation of an authorized representative may be requested at time of application or at other times as required.

Benefits: Healthcare we cover.
**WORDS/PHRASES**

**Community Care Services (CCS):** For Medicaid members who live with a serious mental health issue.

**Co-payment (Co-pay):** A specific dollar amount or percentage of the charge identified that a member pays at the time of service to a healthcare plan, physician, hospital or other provider of care for covered services provided to the member.

**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:** Medical items such as wheelchairs and oxygen tanks.

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

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

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

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

**Emergency Room Care:** Services received in an emergency room.

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

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

**Excluded Services:** Services not covered by your Plan.

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

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

**Generic Drug:** A drug that has the same basic ingredients as a brand-name drug.

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

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

**WORDS/PHRASES**

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

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

**Hospice Services:** Provides care to terminally ill patients who have a life expectancy of 6 or fewer months, as determined by their doctor.

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

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

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

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

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

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

**Medically Necessary Services**: Medical services that are needed for you to get well and stay healthy.

**Member**: A person who has joined our plan.

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

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

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

**‘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.

**Pharmacy Network**: A group of drug stores that members can use.

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

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

**Preferred Drug List (PDL)**: A selection of medicines approved by ‘Ohana doctors and pharmacists in accordance with Hawai‘i laws and regulations for use by members. These drugs are safe and cost less.
### GLOSSARY

**WORDS/PHRASES**

**Premium:** The cost of insurance coverage.

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

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

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

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

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

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

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

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

**Specialist:** A doctor who works in a specific field of medicine.
**WORDS/PHRASES**

**Treatment:** The care you get from doctors and facilities.

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

**WIC (Women, Infants and Children):** A program that helps women, babies and children with nutrition.
GETTING STARTED
WITH US
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.

Your name

Your ‘Ohana ID number

Your PCP’s contact information

How to contact us

Your Medicaid ID number

The date your ‘Ohana membership started

Information your PCP and other providers need to correctly bill for your care/services

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

- See your primary care provider (PCP), a specialist or other provider
- Go to an emergency room, urgent care facility or a hospital for any reason
- Get medical supplies and prescriptions
- Have medical tests done
Call ‘Ohana Customer Service as soon as possible if:

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

2) Using Your Medicare and QUEST Integration (Medicaid) Benefits

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

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

Have Questions?

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

3) Choosing Your PCP

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

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

- Where you may have received services before
- Where you live
GETTING STARTED WITH US

- Your language preference
- If the PCP is accepting new patients
- Gender (in the case of an OB/GYN, as the available PCP)

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

4 Changing Your PCP

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

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

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

For a list of our PCPs:
- Look in your Provider Directory
- Visit our website at www.ohanahealthplan.com
- Call Customer Service

You can learn more about your providers by calling Customer Service. They can tell you about a provider’s schooling or residency, qualifications, or whether he or she accepts new patients. You can also find this information in your Provider Directory.

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

5 Get to Know Your Primary Care Provider (PCP)

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

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

Our PCPs are trained in different specialties. They include:

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

A specialist can be your PCP, provided:

- You have a chronic condition and have a historical relationship with the specialist
- The specialist agrees in writing to assume the responsibilities of the PCP

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

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

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

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

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

**7 Get to Know Your 24-Hour Nurse Advice Line**

Our 24-Hour Nurse Advice Line is offered at no cost to you. You can call the line 24 hours a day, 7 days a week. It is available every day of the year. Call toll-free 1-800-919-8807. Call anytime someone in your family is sick or hurt or needs medical advice.
When you call, a nurse will ask you some questions about your problem. Tell him or her as much as you can – where it hurts, what it looks like and what it feels like. He or she can help you decide if you need to:

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

Call when you need help with problems like:

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

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

8 In an Emergency

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

9 Call Us/Tell Us

Questions? Call us. We can get interpreters for all languages. We have materials available in alternate languages, large print, audiotapes and Braille. Sign language services are also available for hearing-impaired members. All of these services are available at no cost.

Call toll-free 1-888-846-4262 (TTY 711) weekdays from 7:45 a.m. to 4:30 p.m. HST.

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

Customer Service
949 Kamokila Boulevard
3rd Floor, Suite 350
Kapolei, HI 96707
It is important for you to tell ‘Ohana about changes in your life. These changes include:

- Name and address changes
- Family size
- Pregnancy
- Permanent disability
- Accepting a job

‘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 120.

You are now ready to 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 also called “access to care.”)

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

<table>
<thead>
<tr>
<th>Provider</th>
<th>Urban</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCPs, specialists, hospitals, emergency services facilities, mental health providers</td>
<td>30-minute driving time to get to your appointment</td>
<td>60-minute driving time to get to your appointment</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>15-minute driving time to get to a network pharmacy</td>
<td>60-minute driving time to get to a network pharmacy</td>
</tr>
<tr>
<td>24-hour pharmacy</td>
<td>60-minute driving time to get to a network pharmacy</td>
<td>N/A</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Type of Appointment</th>
<th>Type of Care</th>
<th>Appointment Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Emergency</td>
<td>Right away (both in and out of our service area), 24 hours a day, 7 days a week (prior authorization is not required for emergency services; emergency services outside of the U.S. are not covered)</td>
</tr>
<tr>
<td>Urgent and pediatric sickness</td>
<td></td>
<td>Within 24 hours (one day)</td>
</tr>
</tbody>
</table>
## Your Financial Responsibilities

### Cost Sharing

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

**Typically these would be paid to a long-term care facility or home and community-based provider.** You may have to pay for services if:

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

<table>
<thead>
<tr>
<th>Type of Appointment</th>
<th>Type of Care</th>
<th>Appointment Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical (continued)</td>
<td>Adult sickness</td>
<td>Within 72 hours (three days)</td>
</tr>
<tr>
<td></td>
<td>Routine/Wellness</td>
<td>Within 21 days (three weeks)</td>
</tr>
<tr>
<td></td>
<td>Specialist and non-emergency hospital care</td>
<td>Within four weeks (one month)</td>
</tr>
<tr>
<td></td>
<td>Follow-up care after a hospital stay</td>
<td>As needed</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse</td>
<td>Emergency</td>
<td>Right away (both in and out of our service area), 24-hours-a-day, 7 days a week (prior authorization is not required for emergency services; emergency services outside of the U.S. are not covered)</td>
</tr>
<tr>
<td></td>
<td>Routine/Wellness</td>
<td>Within 21 days (three weeks)</td>
</tr>
</tbody>
</table>
**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. These include primary, acute, behavioral health and long-term care services. Your provider cannot bill you a “no show” fee. If you schedule an appointment with your PCP and cannot attend, please call your PCP to tell them. While the provider won’t charge you a “no-show” fee, it is common courtesy to let them know so they can help you reschedule.

<table>
<thead>
<tr>
<th>Behavioral Health Services</th>
<th>Coverage and Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient and Outpatient Mental Health and Substance Abuse</td>
<td>Covered services include all medically necessary behavioral health services for QUEST Integration members:</td>
</tr>
<tr>
<td></td>
<td>• 24-hour-a-day care for acute psychiatric illnesses, including:</td>
</tr>
<tr>
<td></td>
<td>‒ Room and board in an acute hospital</td>
</tr>
<tr>
<td></td>
<td>‒ Nursing care</td>
</tr>
<tr>
<td></td>
<td>‒ Medical supplies and equipment</td>
</tr>
<tr>
<td></td>
<td>‒ Diagnostic services</td>
</tr>
<tr>
<td></td>
<td>‒ Physician services</td>
</tr>
<tr>
<td></td>
<td>‒ Other practitioner services, as needed</td>
</tr>
<tr>
<td></td>
<td>‒ Other medically necessary services</td>
</tr>
<tr>
<td></td>
<td>• Ambulatory services, including 24/7 crisis services</td>
</tr>
<tr>
<td></td>
<td>• Acute day hospital/partial hospitalization, including:</td>
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<tr>
<td></td>
<td>‒ Medication management</td>
</tr>
<tr>
<td></td>
<td>‒ Prescribed drugs</td>
</tr>
<tr>
<td></td>
<td>‒ Medical supplies</td>
</tr>
<tr>
<td></td>
<td>‒ Diagnostic tests</td>
</tr>
<tr>
<td></td>
<td>‒ Therapeutic services, including individual, family and group therapy and aftercare</td>
</tr>
<tr>
<td></td>
<td>‒ Other medically necessary services</td>
</tr>
<tr>
<td>Behavioral Health Services</td>
<td>Coverage and Limits</td>
</tr>
<tr>
<td>----------------------------</td>
<td>---------------------</td>
</tr>
</tbody>
</table>
| **Inpatient and Outpatient Mental Health and Substance Abuse (continued)** | • Methadone treatment services, which include the provision of methadone or a suitable alternative (e.g., LAAM), as well as outpatient counseling services  
• Prescribed drugs including medication management and patient counseling  
• Diagnostic/laboratory services, including:  
  − Psychological testing  
  − Screening for drug and alcohol problems  
  − Other medically necessary diagnostic services  
• Psychiatric or psychological evaluation  
• Physician services  
• Rehabilitation services  
• Occupational therapy  
• Other medically necessary therapeutic services  
*May require prior authorization. See details on page 84.* |
| **Additional Behavioral Health Services** | For members who have a Serious and Persistent Mental Illness (SPMI) and meet the functional eligibility criteria, additional benefits may be available through the Community Care Services (CCS) Program including:  
• Case management  
• Psychosocial rehab  
• Clubhouse  
• Therapeutic living supports  
• Partial or intensive outpatient hospitalization  
*Prior authorization required. See details on page 84.* |
<table>
<thead>
<tr>
<th>Medical Health Services</th>
<th>Coverage and Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Inpatient Hospital Care</strong></td>
<td>Includes the cost of room and board for inpatient stays for:</td>
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<tr>
<td></td>
<td>• Nursing care</td>
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<td></td>
<td>• Medical supplies</td>
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<tr>
<td></td>
<td>• Equipment</td>
</tr>
<tr>
<td></td>
<td>• Drugs</td>
</tr>
<tr>
<td></td>
<td>• Diagnostic services</td>
</tr>
<tr>
<td></td>
<td>• Physical and occupational therapy</td>
</tr>
<tr>
<td></td>
<td>• Audiology</td>
</tr>
<tr>
<td></td>
<td>• Speech-language pathology services</td>
</tr>
<tr>
<td></td>
<td>• All other medically necessary services</td>
</tr>
<tr>
<td></td>
<td><em>May require prior authorization. See details on page 84.</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adult Day Care</th>
<th>Adult day care refers to regular supportive care provided to four or more disabled adult participants.</th>
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<tbody>
<tr>
<td></td>
<td>Services include:</td>
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<tr>
<td></td>
<td>• Observation and supervision by center staff</td>
</tr>
<tr>
<td></td>
<td>• Coordination of behavioral, medical and social plans and implementation of the instructions as listed in the participant’s care plan</td>
</tr>
<tr>
<td></td>
<td>• Therapeutic, social, educational, recreational activities</td>
</tr>
<tr>
<td></td>
<td><em>Prior authorization required. See details on page 84.</em></td>
</tr>
</tbody>
</table>
### Medical Health Services

#### Adult Day Health

Adult day health services are organized day programs for therapeutic, social and health services provided to adults with physical or mental impairments (requires nursing oversight or care). This includes:

- Emergency care
- Dietetic services
- Occupational therapy
- Physical therapy
- Physician services
- Pharmaceutical services
- Psychiatric or psychological services
- Recreational and social activities
- Social services
- Speech-language therapy
- Transportation services

*Prior authorization required. See details on page 84.*

#### Assisted Living Services

Assisted living services include:

- Personal care
- Supportive care services (homemaker, chore, attendant services and meal preparation)

The health plan is not responsible for payment of room and board

*Prior authorization required. See details on page 84.*
### Medical Health Services

<table>
<thead>
<tr>
<th>Coverage and Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some ‘Ohana members may not need the same kind of care they would get in a nursing home, but if they don’t get certain additional services, they could end up going into one.</td>
</tr>
<tr>
<td>Member must live at home and need to meet the “At Risk” criteria. An assessment is completed by your physician or your Service Coordinator.</td>
</tr>
<tr>
<td>At risk services potentially may include:</td>
</tr>
<tr>
<td>- Home-delivered meals</td>
</tr>
<tr>
<td>- Personal Emergency Response System (PERS)</td>
</tr>
<tr>
<td>- Personal care services</td>
</tr>
<tr>
<td>- Adult day care and health</td>
</tr>
<tr>
<td>- Skilled or private duty nursing</td>
</tr>
<tr>
<td>Criteria for each of these services and MQD approval must be met in order to qualify for these services.</td>
</tr>
<tr>
<td><em>Prior authorization required. See details on page 84.</em></td>
</tr>
</tbody>
</table>

### Cognitive Rehabilitation Services

<table>
<thead>
<tr>
<th>Coverage and Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services provided to cognitively impaired persons that assess and treat:</td>
</tr>
<tr>
<td>- Communication skills</td>
</tr>
<tr>
<td>- Cognitive and behavioral ability</td>
</tr>
<tr>
<td>- Cognitive skills related to performing ADLs</td>
</tr>
<tr>
<td>Treatment may last up to one year if the member is making progress.</td>
</tr>
<tr>
<td>Covered services include assessments completed at regular times (determined by the provider and according to the member’s needs).</td>
</tr>
<tr>
<td><em>Prior authorization required. See details on page 84.</em></td>
</tr>
<tr>
<td>Medical Health Services</td>
</tr>
<tr>
<td>-------------------------</td>
</tr>
</tbody>
</table>
| **Community Care Foster Family Home (CCFFH) Services** | Covered services include:  
• Personal care  
• Homemaker services  
• Companion services  
• Day programming  
• Supportive services  
• Attendant care  
• Local transportation  
• Medication oversight (to the extent permitted under state law)  

All services must be provided in a certified private home by a principal care provider who lives in the home.  

*Prior authorization required. See details on page 84.* |
| **Community Care Management Agency (CCMA)** | Covered for members living in community care, foster family homes and other community settings, as required.  

*Prior authorization required. See details on page 84.* |
<table>
<thead>
<tr>
<th>Medical Health Services</th>
<th>Coverage and Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling and Training</td>
<td>Counseling and training activities include:</td>
</tr>
<tr>
<td></td>
<td>• Member care training for members</td>
</tr>
<tr>
<td></td>
<td>• Family and caregivers regarding the nature of the disease and the disease process</td>
</tr>
<tr>
<td></td>
<td>• Methods of transmission and infection control measures</td>
</tr>
<tr>
<td></td>
<td>• Biological, psychological care and special treatment needs/regimens</td>
</tr>
<tr>
<td></td>
<td>• Use of equipment specified in the service plan</td>
</tr>
<tr>
<td></td>
<td>• Employer skills updates as necessary to safely maintain the individual at home</td>
</tr>
<tr>
<td></td>
<td>• Crisis intervention</td>
</tr>
<tr>
<td></td>
<td>• Supportive counseling</td>
</tr>
<tr>
<td></td>
<td>• Family therapy</td>
</tr>
<tr>
<td></td>
<td>• Suicide risk assessments and intervention</td>
</tr>
<tr>
<td></td>
<td>• Death and dying counseling</td>
</tr>
<tr>
<td></td>
<td>• Substance abuse counseling</td>
</tr>
<tr>
<td></td>
<td>• Nutritional assessment and counseling</td>
</tr>
</tbody>
</table>

Counseling and training is a service provided to:

• Members
• Families/caregivers on behalf of the member
• Professional and paraprofessional caregivers on behalf of the member

*Prior authorization required. See details on page 84.*
<table>
<thead>
<tr>
<th>Medical Health Services</th>
<th>Coverage and Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dental Services</strong></td>
<td>‘Ohana Health Plan covers basic adult dental benefits. The covered services include:</td>
</tr>
<tr>
<td></td>
<td>• 1 exam, annually</td>
</tr>
<tr>
<td></td>
<td>• 1 cleaning every 6 months</td>
</tr>
<tr>
<td></td>
<td>• Fluoride treatment 2 times a year</td>
</tr>
<tr>
<td></td>
<td>• 2 bitewing X-rays per year”</td>
</tr>
<tr>
<td></td>
<td>• 2 periapical X-rays per year”</td>
</tr>
<tr>
<td></td>
<td>• Either 1 filling or 1 non-emergency tooth removal each year</td>
</tr>
<tr>
<td></td>
<td>These preventive services must use an ‘Ohana Health Plan-approved dentist.</td>
</tr>
<tr>
<td></td>
<td><em>See “Extra Member Benefits” section on page 62.</em></td>
</tr>
<tr>
<td></td>
<td>Health plan emergency covered services include:</td>
</tr>
<tr>
<td></td>
<td>• Dental services performed by a dentist or physician that are needed due to a medical emergency where the services provided are primarily medical</td>
</tr>
<tr>
<td></td>
<td>• 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</td>
</tr>
<tr>
<td></td>
<td><em>May require prior authorization. See details on page 84.</em></td>
</tr>
<tr>
<td></td>
<td>All other dental services for adults and children are coordinated through Community Case Management Corp. (CCMC) CCMC will help members:</td>
</tr>
<tr>
<td></td>
<td>• Find a dentist</td>
</tr>
<tr>
<td></td>
<td>• Make an appointment</td>
</tr>
<tr>
<td></td>
<td>• Coordinate transportation and translation services</td>
</tr>
<tr>
<td></td>
<td><em>See “Services Covered by Other Agencies” on page 63.</em></td>
</tr>
</tbody>
</table>
### Medical Health Services Coverage and Limits

<table>
<thead>
<tr>
<th>Medical Health Services</th>
<th>Coverage and Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dialysis</strong></td>
<td>Covered services and medical supplies include, but are not limited to the following: • Services  • Equipment  • Supplies  • Diagnostic testing  • Drugs medically necessary  Services may be provided as hospital inpatient, hospital outpatient, in a non-hospital renal dialysis facility or in the members’ home.</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment and Medical Supplies</strong></td>
<td>Covered services and medical supplies include: • Oxygen tanks and concentrators  • Ventilators  • Wheelchairs  • Crutches and canes  • Orthotic devices  • Prosthetic devices  • Medical supplies such as surgical dressings and ostomy supplies  <em>May require prior authorization. See details on page 84.</em></td>
</tr>
<tr>
<td><strong>Early and Periodic Screening Diagnostic and Treatment (EPSDT)</strong></td>
<td>Please see the <a href="#">Well-Child Care and EPSDT (Early and Periodic Screening, Diagnostic and Treatment) Services</a> section on page 91 for details on child health checkups.</td>
</tr>
<tr>
<td>Medical Health Services</td>
<td>Coverage and Limits</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **Emergency Services**               | Covered for medically necessary services. Includes any screening examination services to find out whether an emergency medical condition exists.  
                                          | *No prior authorization required.*                                                                                                                   |
| **Environmental Accessibility Adaptations** | Covered services include:  
                                          | • The installation of ramps and grab-bars  
                                          | • Widening of 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)  
                                          | All services shall comply with state or local building codes. *Prior authorization required. See details on page 84.* |
| **Family Planning Services**         | Covers:  
                                          | • Education and counseling  
                                          | • Emergency contraception  
                                          | • Follow-up  
                                          | • Brief and comprehensive visits  
                                          | • Pregnancy testing  
                                          | • Contraceptive supplies and follow-up care  
                                          | • Diagnosis and treatment of sexually transmitted diseases  
                                          | • Infertility assessment  
                                          | *Family planning does not require a referral from your PCP. Certain procedures may require prior authorization. See details on Page 84.*  
<pre><code>                                      | *‘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.* |
</code></pre>
<table>
<thead>
<tr>
<th>Medical Health Services</th>
<th>Coverage and Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fluoride Varnish</strong></td>
<td>Topical fluoride varnish for children ages 1 to 6 years old</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Habilitation Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>When medically necessary, covered services and devices include:</td>
</tr>
<tr>
<td>• Audiology services</td>
</tr>
<tr>
<td>• Occupational therapy</td>
</tr>
<tr>
<td>• Physical therapy</td>
</tr>
<tr>
<td>• Speech/Language therapy</td>
</tr>
<tr>
<td>• Vision services</td>
</tr>
<tr>
<td>Examples may include:</td>
</tr>
<tr>
<td>• Augmentative communication devices</td>
</tr>
<tr>
<td>• Reading devices</td>
</tr>
<tr>
<td>• Visual aids</td>
</tr>
<tr>
<td>These are excluded when used specifically for activities at school.</td>
</tr>
<tr>
<td>Habilitative services do not include coverage for routine vision services.</td>
</tr>
<tr>
<td><em>May require prior authorization – see details on page 84.</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Education and Counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered services include:</td>
</tr>
<tr>
<td>• Substance use including alcohol</td>
</tr>
<tr>
<td>• Diet and exercise</td>
</tr>
<tr>
<td>• Injury prevention</td>
</tr>
<tr>
<td>• Sexual behavior</td>
</tr>
<tr>
<td>• Dental health</td>
</tr>
<tr>
<td>• Family violence</td>
</tr>
<tr>
<td>• Depression</td>
</tr>
<tr>
<td>• Results and implications of screenings listed above</td>
</tr>
<tr>
<td><em>May require prior authorization. See details on page 84.</em></td>
</tr>
<tr>
<td>Medical Health Services</td>
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<tr>
<td><strong>Hearing</strong></td>
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<td><strong>Home Health Services</strong></td>
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<td><strong>Home Maintenance</strong></td>
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<td></td>
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<tr>
<td>Medical Health Services</td>
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<tr>
<td>--------------------------</td>
</tr>
<tr>
<td><strong>Home-Delivered Meals</strong></td>
</tr>
<tr>
<td><strong>Hospice Services</strong></td>
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<tr>
<td><strong>Hysterectomies</strong></td>
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<tr>
<td>Medical Health Services</td>
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<tr>
<td><strong>Licensed Residential Care</strong></td>
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<tr>
<td><strong>Long-Term Care – Institutional Services</strong></td>
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<tr>
<td><strong>Maternity Services</strong></td>
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<td>Medical Health Services</td>
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<td>Moving Assistance</td>
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<thead>
<tr>
<th>Nursing Facility Services – Both Intermediate and Skilled Nursing</th>
<th>Covered for members who need 24-hour-a-day help with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). These members need regular, long-term care from licensed nurses and paramedical personnel. Long-term services require MQD approval through the 1147 process.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Care is provided in a nursing facility that includes:</td>
</tr>
<tr>
<td></td>
<td>• Independent and group activities</td>
</tr>
<tr>
<td></td>
<td>• Meals and snacks</td>
</tr>
<tr>
<td></td>
<td>• Housekeeping and laundry services</td>
</tr>
<tr>
<td></td>
<td>• Nursing and social work services</td>
</tr>
<tr>
<td></td>
<td>• Nutritional monitoring and counseling</td>
</tr>
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<td></td>
<td>• Pharmaceutical services and rehabilitative services</td>
</tr>
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<td></td>
<td>May require prior authorization – see details on page 84.</td>
</tr>
<tr>
<td>Medical Health Services</td>
<td>Coverage and Limits</td>
</tr>
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<td>-------------------------</td>
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</tbody>
</table>
| **Other Practitioner Services** | Covered services include but are not limited to:  
• Certified nurse midwife services  
• Licensed advanced practice registered nurse services (including family, pediatric, geriatric, psychiatric health specialists)  
• Other medically necessary practitioner services provided by a licensed or certified healthcare provider |
| **Out-of-State and Off-Island Coverage** | We provide any medically necessary covered services that are prearranged when not available on your island or in Hawai‘i. This includes:  
• Referrals to an out-of-state or off-island specialist or facility  
• Transportation to and from the referral destination  
• Lodging and meals  
• An adult attendant that the member chooses (if medically necessary and authorized)  
*May require prior authorization – see details on page 84.* |
| **Outpatient Hospital Care** | This service includes 24/7 care for:  
• Emergency services  
• Ambulatory center services  
• Urgent care services  
• Medical supplies  
• Equipment and drugs  
• Diagnostic services  
• Therapeutic services (including chemotherapy and radiation therapy)  
• Other medically necessary services  
*May require prior authorization – see details on page 84.* |
## Medical Health Services

<table>
<thead>
<tr>
<th>Medical Health Services</th>
<th>Coverage and Limits</th>
</tr>
</thead>
</table>
| **Outpatient Hospital Procedures** | Covered services include:  
• Sleep laboratory services and  
• Surgeries performed in a free-standing ambulatory surgery center (ASC) and in a hospital ASC.  
*M May require prior authorization – see details on page 84.* |
| **Personal Assistance Services – Level 1** | May be covered when authorized by the Service Coordinator for members who need help with key daily activities to prevent a decline in health status and keep them in their home. Services may include:  
Services may include:  
• Meal preparation  
• Laundry  
• Shopping  
• Errands  
• Light housekeeping tasks  
*Prior authorization required. See details on page 84.* |
### Personal Assistance Services – Level 2

**Medical Health Services** | **Coverage and Limits**
---|---

Covered for those who need help with daily activities and keeping up their health.

This level of service is to be provided by a Home Health Aide (HHA), Personal Care Aide (PCA), Certified Nurse Aide (CNA) or Nurse Aide (NA) with applicable skills.

Some activities include:

- Personal hygiene and grooming, including bathing, skin care, oral hygiene, hair care and dressing
- Help with bowel and bladder care
- Help with mobility
- Help with transfers
- Help with medications
- Help with routine or maintenance healthcare services by a personal care provider
- Help with feeding, nutrition, meal preparation and other dietary activities
- Help with exercise, positioning and range of motion
- Taking and recording vital signs, including blood pressure
- Measuring and recording intake and output, when ordered
- Collecting and testing specimens as directed

*Prior authorization required. See details on page 84.*
## Medical Health Services

### Coverage and Limits

**Personal Emergency Response Systems (PERS)**

PERS are devices to help members who are at a high risk of having to go the hospital. They can get help in case of an emergency.

- PERS items include electronic devices or services designed for emergency assistance

PERS services are limited to those individuals:

- Who live alone
- Who are alone for significant parts of the day
- Who have no regular caregiver for extended periods
- Who would otherwise need extensive routine supervision

PERS services will only be offered to a member living in a non-licensed setting except for an ALF.

*Prior authorization required. See details on page 84.*

### Physician Services

Services must be medically necessary and provided at locations including:

- Physicians’ offices
- Clinics
- Private homes
- Licensed hospitals
- Licensed skilled nursing facility
- Intermediate care facility
- Licensed or certified residential setting

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## Podiatry Services

Covered services include:

- Professional services, not involving surgery, provided in the office or clinic
- Professional services, not involving surgery, related to diabetic foot care in an outpatient or inpatient hospital
- Surgical procedures involving the ankle and below
- Diagnostic radiology procedures
- Foot and ankle care related to treatment of infection or injury in the office or an outpatient clinic
- Bunionectomies are covered only when the bunion is present with overlying skin ulceration or neuroma secondary to the bunion

## Post-Stabilization Services

The plan will cover post-stabilization care services at all times, inpatient and outpatient, related to an emergency medical condition after a member is stabilized, to maintain the stabilized condition, or to improve or resolve the member’s condition. Post-stabilization services include follow-up outpatient specialist care.

## Prescription Drugs

Covers drugs listed on our Preferred Drug List (PDL). This list will also have drugs that may have limits such as prior authorization, quantity limits, step therapy, age limits or gender limits. Alternate drugs may be covered with a prior authorization.
## Medical Health Services

<table>
<thead>
<tr>
<th>Preventive Services</th>
<th>Coverage and Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services include:</td>
<td>• Initial and interval histories</td>
</tr>
<tr>
<td></td>
<td>• Comprehensive physical examinations (including developmental services)</td>
</tr>
<tr>
<td></td>
<td>• Immunizations</td>
</tr>
<tr>
<td></td>
<td>• Family planning</td>
</tr>
<tr>
<td></td>
<td>• Diagnostic and screening laboratory</td>
</tr>
<tr>
<td></td>
<td>• X-ray services (including screening for tuberculosis)</td>
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<td></td>
<td><em>May require prior authorization. See details on page 84.</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Private-Duty Nursing</th>
<th>Covered for those who need ongoing nursing care.</th>
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</thead>
<tbody>
<tr>
<td>The service is provided by licensed nurses within the scope of state law.</td>
<td><em>Prior authorization required. See details on page 84.</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Radiology/Laboratory/Other Diagnostic Services</th>
<th>Covered services include:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Diagnostic</td>
</tr>
<tr>
<td></td>
<td>• Therapeutic radiology and imaging</td>
</tr>
<tr>
<td></td>
<td>• Screening and diagnostic laboratory tests</td>
</tr>
<tr>
<td></td>
<td><em>May require prior authorization. See details on page 84.</em></td>
</tr>
<tr>
<td>Medical Health Services</td>
<td>Coverage and Limits</td>
</tr>
<tr>
<td>-------------------------</td>
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</tr>
</tbody>
</table>
| **Rehabilitation Services** | Covered services include:  
• Physical and occupational therapy  
• Audiology and speech/language therapy  
*May require prior authorization. See details on page 84.* |
| **Respite Care** | Respite care is short-term based care. It provides relief to caregivers. It may be provided hourly, daily and overnight.  
Respite care may be provided in the following locations (based on current care member is receiving):  
• Member’s home or place of residence  
• Foster home or expanded-care adult residential care home  
• Medicaid-certified nursing facility  
• Licensed respite day care facility  
• Other community care residential facility approved by the Plan  
Respite care services are authorized by the member’s PCP as part of the member’s care plan.  
*Prior authorization required. See details on page 84.* |
| **Smoking Cessation** | Covered services include:  
• Medication  
• Counseling  
• Two quit attempts per benefit period |
### Specialized Medical Equipment Warranty and Supplies

<table>
<thead>
<tr>
<th>Medical Health Services</th>
<th>Coverage and Limits</th>
</tr>
</thead>
</table>
| Specialized Medical Equipment Warranty and Supplies | Refers to the purchase, rental, lease, warranty and supplies costs, installation, repairs and removal of devices, controls or appliances that member was already approved for and that was specified in the care plan. This also includes:  
  • Items necessary for life support  
  • Supplies and equipment needed for the proper functioning of such items  
  • Durable and non-durable medical equipment not available under the Medicaid state plan  
  Examples include:  
  • Specialized infant car seats  
  • Modification of parent-owned motor vehicle to accommodate the child, e.g., wheelchair lifts  
  • Intercoms for monitoring the child’s room  
  • Shower seat  
  • Portable humidifiers  
  • Electric bills specific to electrical life support devices (ventilator, oxygen concentrator)  
  • Medical supplies  
  *Prior authorization required. See details on page 84.* |

### Sterilizations

<table>
<thead>
<tr>
<th>Medical Health Services</th>
<th>Coverage and Limits</th>
</tr>
</thead>
</table>
| Sterilizations | Covered for both men and women if:  
  • You are at least 21 years of age at the time consent is obtained  
  • You are mentally competent  
  • You voluntarily give informed consent by completing the Informed Consent for Sterilization Form  
  • Your provider completes the Sterilization Required Consent Form  
  *May require prior authorization. See details on page 84.* |
<table>
<thead>
<tr>
<th>Medical Health Services</th>
<th>Coverage and Limits</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Covered for members 18 years or older who meet the following criteria:</td>
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<tr>
<td></td>
<td>- Chronically homeless under the Housing and Urban Development (HUD) definition, or</td>
</tr>
<tr>
<td>Supportive Housing</td>
<td>- Is experiencing homelessness and has one of the qualifying health conditions listed below, or</td>
</tr>
<tr>
<td>Services</td>
<td>- Is living in an institution and cannot be discharged due to lack of stable housing and has one of the qualifying health conditions listed below, or</td>
</tr>
<tr>
<td></td>
<td>- Is living in public housing and at risk of eviction and has one of the qualifying health conditions listed below.</td>
</tr>
<tr>
<td>Qualifying health conditions:</td>
<td>- A mental health disorder that interferes with one of more major life activities, or</td>
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<tr>
<td></td>
<td>- Has been diagnosed with substance use disorder (SUD), or</td>
</tr>
<tr>
<td></td>
<td>- Chronic physical or complex health needs, or</td>
</tr>
<tr>
<td></td>
<td>- Frequent emergency department/inpatient hospital use</td>
</tr>
<tr>
<td>Services are divided into three categories:</td>
<td>• Pre-Tenancy Services</td>
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<tr>
<td></td>
<td>- Screening/assessments</td>
</tr>
<tr>
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<td>- Develop housing support plan</td>
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<td>- Housing search</td>
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<td>- Applications prep and submission</td>
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<td></td>
<td>- Identify resources/costs for start-up needs</td>
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<td></td>
<td>- Identify equipment, technology and other modifications needed</td>
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<td></td>
<td>- Ensure housing is safe</td>
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<td></td>
<td>- Moving assistance</td>
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<td>- Individualized housing crisis plan</td>
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<table>
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<tr>
<th>Supportive Housing Services (continued)</th>
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<tbody>
<tr>
<td>• Tenancy Services</td>
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<tr>
<td>- Individual housing and tenancy sustaining services</td>
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<tr>
<td>- Early identification/intervention for negative behaviors</td>
</tr>
<tr>
<td>- Education/training roles and responsibilities of tenant/landlord</td>
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<tr>
<td>- Coach on development/maintenance of relationships between landlords/property managers</td>
</tr>
<tr>
<td>- Dispute resolution with landlords/neighbors</td>
</tr>
<tr>
<td>- Advocate and link with advocacy groups to help prevent eviction</td>
</tr>
<tr>
<td>- Housing recertification process</td>
</tr>
<tr>
<td>- Update/maintain housing support and crisis plans</td>
</tr>
<tr>
<td>- Development of daily living skills and maintaining a residence skills to sustain residency</td>
</tr>
<tr>
<td>- Service care coordination</td>
</tr>
<tr>
<td>- Housing crisis management</td>
</tr>
<tr>
<td>• Other Housing and Tenancy Support Services</td>
</tr>
<tr>
<td>- Job skills training employment activities</td>
</tr>
<tr>
<td>- Peer supports</td>
</tr>
<tr>
<td>- Non-medical transportation</td>
</tr>
<tr>
<td>- Support groups</td>
</tr>
<tr>
<td>- Caregiver/family support</td>
</tr>
<tr>
<td>- Outreach and in-reach services</td>
</tr>
<tr>
<td>- Health management</td>
</tr>
<tr>
<td>- Counseling and therapies</td>
</tr>
<tr>
<td>- Services assessments</td>
</tr>
<tr>
<td>- Service plan development</td>
</tr>
<tr>
<td>- Independent living skills/financial literacy</td>
</tr>
<tr>
<td>- Equipment, technology and other modifications</td>
</tr>
<tr>
<td>- Home management</td>
</tr>
<tr>
<td>- Other supplemental services as needed</td>
</tr>
</tbody>
</table>

*May require prior authorization. See details on page 84.*
### Telehealth Services

Services may include, but are not limited to:

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

Services not covered include:

- Standard phone calls, faxes or email – in combination or individually – are not considered Telehealth Services
- Getting your medication by filling out an online form is not a Telehealth Service

If you get in-person care that needs prior approval, you will need prior approval to get the same care through Telehealth.

Providers will tell you if they provide Telehealth Services. Your provider will bill the plan for these services.

### Transplant Services

Cornea transplants and bone grafts are covered

*May require prior authorization. See details on page 84.*

Other transplants are covered under the State of Hawai‘i Organ and Tissue Transplant Program, not the QUEST Integration program.
<table>
<thead>
<tr>
<th>Medical Health Services</th>
<th>Coverage and Limits</th>
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</thead>
<tbody>
<tr>
<td><strong>Transportation Services</strong></td>
<td>The plan provides emergency and non-emergency ground and air services to and from medically necessary medical appointments for members who:</td>
</tr>
<tr>
<td></td>
<td>• Have no means of transportation</td>
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<tr>
<td></td>
<td>• Reside in areas not served by public transportation</td>
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<tr>
<td></td>
<td>• Cannot access public transportation due to their medical condition</td>
</tr>
<tr>
<td></td>
<td>• Do not live in a community foster family home, adult residential care home, expanded adult residential care home, or domiciliary home</td>
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<tr>
<td></td>
<td>Transportation is not provided to day programs that are not medically necessary</td>
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<tr>
<td></td>
<td>Transportation is not provided to adult dental appointments that are part of the Extra Member Benefits.</td>
</tr>
<tr>
<td></td>
<td>To learn more about transportation, see page 73.</td>
</tr>
<tr>
<td></td>
<td>May require prior authorization. See details on page 84.</td>
</tr>
<tr>
<td><strong>Urgent Care Services</strong></td>
<td>Covered as medically necessary. No prior authorization is required.</td>
</tr>
<tr>
<td>Medical Health Services</td>
<td>Coverage and Limits</td>
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<tr>
<td>-------------------------</td>
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</tr>
<tr>
<td><strong>Vision Services</strong></td>
<td>We provide ophthalmologist eye and vision services for members:</td>
</tr>
<tr>
<td></td>
<td>21 and older – once every 2 years younger than 21 – once every year</td>
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<tr>
<td></td>
<td>More visits may be allowed, depending on the symptoms or medical condition.</td>
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<tr>
<td></td>
<td>Covered services include:</td>
</tr>
<tr>
<td></td>
<td>• Vision examinations</td>
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<tr>
<td></td>
<td>• Cataract removal</td>
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<tr>
<td></td>
<td>• Ophthalmologic exam with refraction</td>
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<td></td>
<td>• Prescription lens</td>
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<tr>
<td></td>
<td>• Prosthetic eyes</td>
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<tr>
<td></td>
<td>• Visual aids are covered once in a 24-month period</td>
</tr>
<tr>
<td></td>
<td>Premier provides this care for you. Call Customer Service to:</td>
</tr>
<tr>
<td></td>
<td>• Find a provider</td>
</tr>
<tr>
<td></td>
<td>• Make an appointment</td>
</tr>
<tr>
<td></td>
<td>• Coordinate transportation and translation services</td>
</tr>
<tr>
<td></td>
<td>New lenses if medically necessary:</td>
</tr>
<tr>
<td></td>
<td>• Once every 2 years</td>
</tr>
<tr>
<td></td>
<td>Replacement glasses and/or new glasses with major changes in prescription are covered within the benefit periods with prior authorization.</td>
</tr>
</tbody>
</table>
Extra Member Benefits

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

Basic Adult Dental Care

We understand the importance of good oral health, and believe you shouldn’t have to wait until it becomes an emergency to take care of your teeth. That’s why adult members with our QUEST Integration as their only source of medical insurance will be eligible for the below:

- 1 exam, once a year
- 1 cleaning every 6 months
- Fluoride treatment, 2 times a year
- 2 bitewing X-rays per year
- 2 periapical X-ray per year
- Either 1 filling or 1 non-emergency tooth removal each year.

You must use a dentist in the ‘Ohana Health Plan network. Call us or visit our website to use our Find a Provider/Pharmacy tool to find a dentist who participates in this program. Because this is an extra benefit, we cannot offer transportation to these dental appointments.

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

We understand the importance of education, which is why we’re offering this program

- You can take the GED or HiSET tests for free if you’re age 18 or older and don’t have your high school diploma
- Visit our website to:
  - Read Frequently Asked Questions (FAQ)
  - Get the registration form
  - Find help preparing for the test

Over-the-Counter (OTC) Supplies

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

We have three easy ways to order:

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

Services Covered by Other Agencies

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

Mental Health Services

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

<table>
<thead>
<tr>
<th>Family Guidance Center</th>
<th>Location</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>O'ahu</td>
<td></td>
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</tr>
<tr>
<td>Central O'ahu</td>
<td>Pearl City</td>
<td>808-453-5900</td>
</tr>
<tr>
<td>Family Court Liaison Branch</td>
<td>Kailua</td>
<td>808-266-9922</td>
</tr>
<tr>
<td>Honolulu</td>
<td>Honolulu</td>
<td>808-733-9393</td>
</tr>
<tr>
<td>Leeward O'ahu</td>
<td>Kapolei</td>
<td>808-692-7700</td>
</tr>
<tr>
<td>Windward Kane'ohe</td>
<td>Kane'ohe</td>
<td>808-233-3770</td>
</tr>
<tr>
<td>Hawai'i</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hilo</td>
<td>Hilo</td>
<td>808-933-0610</td>
</tr>
<tr>
<td>Waimea</td>
<td>Kamuela</td>
<td>808-887-8100</td>
</tr>
<tr>
<td>Kailua Kona</td>
<td>Kealakekua</td>
<td>808-322-1541</td>
</tr>
<tr>
<td>Kaua'i</td>
<td>Lihu'e</td>
<td>808-274-3883, ext. 231</td>
</tr>
</tbody>
</table>
AMHD stands for Adult Mental Health Division. AMHD runs a 24-hour call center called the Crisis Line of Hawai’i. When you call the Crisis Line of Hawai’i, you can get important information about mental health resources. You also get access to crisis services. You can call the Crisis Line of Hawai’i toll-free at 1-800-753-6879. On O’ahu, call 832-3100.

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

**Development Disability Waiver Program**

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

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

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

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

**Dental**

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

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

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

Intentional Termination of Pregnancy

Intentional terminations of pregnancy are not covered by ‘Ohana. They are covered by the DHS. You will need authorization. Your provider will need to call Xerox. For O‘ahu, call 808-952-5570. For Neighbor Islands, call 1-800-235-4378. Your doctor must also submit the claim to Xerox.

You can get transportation to your appointment. Call 1-808-692-8124.

Additional Services for Children

Children may qualify for more services with these programs.

- The Early Intervention Program for children with suspected (developmental) delays – call the Early Intervention Program Referral Line toll-free at 1-800-235-5477 (on O‘ahu, call 1-808-594-0066)

- Department of Education (DOE) school-based services — call the DOE at 1-808-586-3230 or 1-808-586-3232

Women, Infants and Children (WIC) Program

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

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

Are you pregnant? You can ask your doctor to complete a WIC application. Or you can visit your local health department. You may also call WIC toll-free at 1-888-820-6425. On O‘ahu, call 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 are receiving some non-covered services. Please see the list of non-covered services in the chart below for more details

‘Ohana is liable only for services authorized by us. But, a non-covered service might be covered if it is medically necessary.

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

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

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<td>• There is more than 1 purpose for performing the hysterectomy (but the primary purpose is to render the member permanently incapable of reproducing)</td>
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### Non-Covered Services

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<td></td>
<td>- Contacts for cosmetic reasons</td>
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PRESCRIPTION DRUG SERVICES

Prescriptions and Pharmacy Access

How do I get a prescription?

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

Which drug stores will fill my prescription?

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

What is the process for getting a prescription filled?

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

Preferred Drug List

What medicines do we pay for?

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

Go to www.ohanahealthplan.com. You can also call Customer Service to ask for a printed PDL to be mailed to you.
Are there medicines we will not pay for?
The plan does not pay for these medicines:
- Those used to help you get pregnant
- Those used for eating problems, weight loss or weight gain
- Those used for erectile dysfunction
- Those that are used for cosmetic purposes or to help you grow hair
- Vitamins, except for prenatal vitamins and those listed on the PDL
- DESI (Drug Efficacy Study Implementation) drugs and drugs that are identical, related or similar to such drugs
- Investigational or experimental drugs
- Those used for any purpose that is not medically accepted

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

Are generic drugs as good as brand-name drugs?
Yes. Generic drugs work the same as brand drugs. They have the same active ingredients as brand drugs.

Other Drugs You Can Get at the Pharmacy

Do we pay for OTC drugs?
As an additional benefit, there are some over-the-counter (OTC) drugs you can get at the pharmacy with a prescription at no cost. Some of these drugs we cover include:
- Aspirin
- Ibuprofen (a pain reliever for headaches, toothaches and back pain)
- Diphenhydramine (for allergy relief)
• Non-sedating antihistamines (allergy relief that won’t make you sleepy)
• Insulin
• Insulin syringes
• Urine test strips
• Antacids
• H-2 receptor antagonist (a type of drug that reduces stomach acid)
• Proton pump inhibitors (a type of drug that reduces stomach acid)
• Multivitamins/multivitamins with iron
• Iron
• Topical anti-fungals
• Meclizine (a type of drug that helps nausea and dizziness)

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

Direct Member Reimbursement

What is a medication Direct Member Reimbursement?

Sometimes you may pay for medications out of pocket at a retail drug store. This can happen if you forget to show your ‘Ohana QUEST Integration ID card. After such a purchase, you have 36 months to send us a claim form and your receipts to recover your costs. This is called Direct Member Reimbursement (DMR). To get a copy of the claim form, call Customer Service toll-free at 1-888-846-4262 (TTY 711).

We’re here for you Monday–Friday from 7:45 a.m. to 4:30 p.m. HST. You can also go to www.ohanahealthplan.com.

Where do I send my request?

Send the form to:
‘Ohana Health Plan
Reimbursement Department
P.O. Box 31577
Tampa, FL 33631-3577
What do I need to include with each DMR request for approval?

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

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

How much will I get back?

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

How long should I expect to wait for my reimbursement?

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

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

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

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

Services may include:

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

Services not covered include:

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

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

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

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

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

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

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

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

**AND**

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

**AND**

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

**Taxi service will be used:**

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

**OR**

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

**OR**

• If your destination is more than a half-mile from a bus stop
TheHandi-Van will be used:

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

You must be certified to ride TheHandi-Van.

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

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

Questions?

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

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

Also, talk with your provider about ongoing appointments. He or she can ask NET for you.

3 steps for using your transportation benefit

1. Schedule a ride by calling IntelliRide toll-free. The number is 1-866-790-8858. Customer Service can also help.

2. Call at least three business days before your off-island or out-of-state appointment. For ground transportation on your home island, please call IntelliRide at least 48 hours before your appointment. You can schedule a ride as long as 30 days before your appointment.

3. Be ready at least 15 minutes before your pick-up time.
NET service reminders

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

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

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

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

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

What is the Pharmacy Lock-In Program?
The program helps manage your prescription drug and medical care needs. If you are identified for this program, you will get all of your controlled substance prescriptions from one assigned pharmacy and/or one prescriber. This will help your pharmacist and doctor understand your prescription needs.

In this program, you may see different doctors for your care and each doctor may prescribe a different drug for you, which can be dangerous. We are committed to you having a clear understanding of these dangers.

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

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

As part of the ‘Ohana Lock-In Program, you will have access to a Care Team for additional support. A Service Coordinator can work with you to create an individualized Care Plan. Service Coordinators provide monitoring, education, communication and collaboration, and can help with access to other treatments to improve your health. There is no cost to you and this is a voluntary service.

For questions about our ‘Ohana Lock-In Program or to begin working with a Care Team, please call us toll-free at 1-888-846-4262 Monday–Friday, from 7:45 a.m. to 4:30 p.m. HST. TTY/TDD users may call 711.
SERVICE COORDINATION

‘Ohana has a Service Coordination Program to help you better understand your health conditions and how to use your medical plan services. Our service coordination (SC) teams are led by healthcare professionals, like nurses, social workers and behavioral health specialists. They assess your risk factors, develop an individualized treatment plan, establish treatment goals, monitor outcomes and evaluate the outcome for possible revisions of the care plan.

This program is used to enhance the care you receive from your provider. It does not replace any service.

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

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

This program may be good for you if you:

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

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

• Health history
• Existing services
This helps us match you up with the Service Coordinator who best meets your needs. Then he or she will call you to set up a face-to-face visit to learn more about your health history.

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

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

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

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

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

Our programs include the following:

• Diabetes mellitus
• Depression
• Asthma
• Coronary Artery Disease

In addition:

• After Hospital Outreach Program (AHOP) for Congestive Heart Failure (CHF)
• Referral to Hawai‘i Tobacco Quit Line

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

To learn more, you may contact Customer Service toll-free at 1-888-846-4262 and ask for the Disease Management Department. TTY users may call 711.
**BEHAVIORAL HEALTH SERVICES**

We can help you get an outpatient mental health or substance abuse assessment for you or someone in your family. Call your Service Coordinator or Customer Service to find out more. Our staff will be happy to help you. You do not need prior approval from your PCP. We will give you names of providers near you. You may choose from these names to set up an appointment.

**What to Do if You Are Having a Problem**

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

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

You do not need to call your PCP for a referral. You may see any in-network behavioral health provider you like without a referral or permission from ‘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 assistance.

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

First, decide if it is a true emergency. Do you think you are a danger to yourself or others? If you think you are, call 911. Or go to the nearest emergency room. Do this even if the emergency room is not in our service area.
If you need emergency healthcare outside our service area, please tell us. Just call the number on your ID card. You should also call your PCP if you can. Call your PCP again in 24 to 48 hours. Once you are stable, plans will be made to transfer you to a Medicaid facility.

**Behavioral Health Limitations and Exclusions**

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

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

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

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 moms-to-be and their babies
- Programs for kids
HOW TO GET SERVICES

Services That Require a Referral
Your PCP will need to make a referral for you to get certain services. These include:

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

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

Services Available Without a Referral (Self-Referral Services)
You do not need approval from your PCP or the plan for these services. Please see the Covered Services section for more details about the below services. If you have any questions, please call Customer Service toll-free at 1-888-846-4262. TTY users may call 711.

• Emergency and urgent care services
• Family planning services
• Routine checkups and treatment from your assigned PCP
• Well-child, EPSDT and treatment visits for children up until their 21st birthday
• Annual wellness visits for women, including a Pap smear
• Lab tests
• Basic X-rays
• Routine vision
• Routine behavioral health outpatient services
• Disease management

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

You can find a list of providers on the Web. Just visit www.ohanahealthplan.com. You can also call Customer Service to ask for a directory.

Services From Providers Not in Our Network

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

Services That Require Prior Authorization/Precertification

We need to approve the following services before you can get them. This is called prior authorization or precertification. If you have ongoing special healthcare needs, you have direct access to specialists; however, ‘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.

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

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

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

Utilization Management Program

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

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

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

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

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

To learn more about our UM program, you may contact Customer Service toll-free at 1-888-846-4262. TTY users call 711.

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

If ‘Ohana objects to providing a service on moral or religious grounds, we will notify you within 90 days after 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 with arranging a second opinion. They will ask you to pick a plan doctor in your area. If you can’t find another plan doctor in your area, your PCP will ask you to pick one who is as close to you as possible and in our plan. If no plan doctor is available, your PCP can help you choose one who is not in our plan. Your PCP will get authorization for this visit.

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

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

How to Get After-Hours Care

If you get sick or hurt, and it is not an emergency, call your PCP. Your PCP’s office will direct you on how to get care. If you can’t reach your doctor, you 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 27.)
EMERGENCY SERVICES

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

What to Do in an Emergency

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

Some examples of emergencies are:

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

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

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

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

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

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

**Post-Stabilization Services**

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

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

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

**Out-of-Area Emergency Care**

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

What should you do if you get sick or hurt while out of the ‘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 will need to pay for these services yourself.
What to Do if You Need Urgent Care

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

- Injury
- Illness
- Severe pain

Not sure you need urgent care? Call your PCP or our 24-Hour Nurse Advice Line. Urgent care center services do not need prior approval. You will need to show your ‘Ohana and Medicaid ID cards at the urgent care center.

Out-of-State and Off-Island Coverage

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

This includes:

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

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

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

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

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

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

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

Transition of Care

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

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

Please call Customer Service to help arrange the transition you need.
WELL-CHILD CARE AND EPSDT (EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT) SERVICES

‘Ohana has an EPSDT program. It stands for “Early and Periodic Screening, Diagnostic and Treatment.” It provides needed care for children up to age 21. EPSDT care may include services like:

- Preventive care for members from newborn through age 20
- Services and medications
- Lab tests (as needed)
- Prescriptions (as needed)
- A comprehensive history and physical exam
- Behavioral and mental health assessment
- Growth and development chart
- Vision, hearing and language screening
- Nutritional health and education
- Lead risk assessment and testing, as appropriate
- Age-appropriate immunizations
- Dental screening and referral to dentist
- Referral to specialists and treatment, as appropriate
- Intensive Behavioral Therapies (e.g., Applied Behavioral Analysis (ABA) services for members with an Autism Spectrum Disorder (ASD) diagnosis
- Any needed services as part of a treatment plan that is approved as medically necessary by the plan
- Regular preventive dental and treatment services, including screening examinations, prophylactic treatment (scaling and polishing), following the Academy of Pediatric guidelines

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

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

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

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

Why is the well-child checkup important?

Checkups help find health concerns before they become bigger problems. Also, your child can get the shots he or she needs during these visits.

When should a well-child checkup occur?

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

- At birth, in the hospital
- 3–5 days
- 1 month old
- 2 months old
- 4 months old
- 6 months old
- 9 months old
- 12 months old
- 15 months old
- 18 months old
- Every year during ages 2–6 years old
- Even years from age 6 to 20
How much does a well-child checkup cost me?
Nothing. Checkups are done by your child’s PCP at no cost to you.

What if I need help getting a doctor visit?
We can help you get an appointment. Just call Customer Service toll-free at 1-888-846-4262. TTY users may call 711. We’re here for you from 7:45 a.m. to 4:30 p.m. HST.

What if I need help getting to the doctor visit?
We can help you get a ride to the doctor. Call Customer Service toll-free at 1-888-846-4262. TTY users may call 711. We’re here for you from 7:45 a.m. to 4:30 p.m. HST.
**PEdiatric Preventive Health Guidelines**

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

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

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

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

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

**Pediatric Preventive Health Guidelines – Newborn to 21 Years Old**

<table>
<thead>
<tr>
<th>Age</th>
<th>Well-Child Checkups and Shot Guide</th>
</tr>
</thead>
</table>
| **Newborn** | • Well-baby checkup* at birth  
• Hearing screening  
• Newborn screening blood tests  
• Dose 1 of 2 of the Hepatitis B (HepB) vaccine |
| **3–5 days** | • This visit is especially important if your baby was sent home within 48 hours of birth  
• Well-baby checkup as recommended by your doctor  
• Newborn screening blood tests  
• Dose 1 of 2 of the Hepatitis B (HepB) vaccine, if not done at birth |
<table>
<thead>
<tr>
<th>Age</th>
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</tr>
</thead>
</table>
| 1 month | • Well-baby checkup  
          • Newborn screening blood tests if not already completed  
          • Dose 2 of 2 of the Hepatitis B (HepB) vaccine, if not already received  
          • TB screening |
| 2 months | • Well-baby checkup  
               • Newborn screening blood tests if not already completed  
               • Rotavirus (RV); Diphtheria, Tetanus, and Pertussis (DTaP); Haemophilus influenza type b (Hib); Pneumococcal conjugate (PCV); and inactivated poliovirus (IPV) vaccines |
| 4 months | • Well-baby checkup  
               • Newborn screening blood tests if not already completed  
               • Rotavirus (RV); Diphtheria, Tetanus, and Pertussis (DTaP); Haemophilus influenzae type b (Hib); Pneumococcal conjugate (PCV); and inactivated poliovirus (IPV) vaccines  
               • DTaP, Hib, IPV, PCV and RV vaccines, Hemoglobin (Hgb) screening |
| 6 months | • Well-baby checkup  
                • Newborn screening blood tests if not already completed  
                • Dose 3 of the Hepatitis B (HepB) vaccine (recommended between ages 6 to 18 months)  
                • Rotavirus (RV); Diphtheria, Tetanus, and Pertussis (DTaP); Pneumococcal conjugate (PCV); and inactivated poliovirus (IPV) vaccines  
                • Begin yearly flu shot (fall or winter)  
                • TB screening, oral health screening and blood lead risk assessment |
## Age 9 months

- Well-baby checkup
- Newborn screening blood tests if not already completed, including hemoglobin or hematocrit
- Dose 3 of the Hepatitis B (HepB) vaccine (if not already received; recommended between ages 6 to 18 months)
- Dose 3 the inactivated poliovirus (IPV) vaccines (if not already received; recommended between ages 6 to 18 months)
- Yearly flu shot if not already received
- Screenings for TB, developmental health, and oral health as well as a blood lead risk assessment

## Age 12 months

- Well-baby checkup
- Catch-up immunizations as needed
- Newborn screening blood tests if not already completed, including hemoglobin or hematocrit if not done at 9-month visit
- Dose 3 of the Hepatitis B (HepB) vaccine (if not already received; recommended between ages 6 to 18 months)
- Dose 3 of the inactivated poliovirus (IPV) vaccines (if not already received; recommended between ages 6 to 18 months)
- Haemophilus influenza type b (Hib); Pneumococcal conjugate (PCV); Varicella (VAR); Measles, Mumps, Rubella (MMR); and the Hepatitis A (HepA) vaccines
- Yearly flu shot if not already received
- Screenings for TB, developmental health, and oral health as well as a blood lead risk assessment
- Dental visit as need-identified by child’s doctor**
<table>
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<tr>
<th>Age</th>
<th>Well-Child Checkups and Shot Guide</th>
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<tbody>
<tr>
<td>15 months</td>
<td>• Well-baby checkup</td>
</tr>
<tr>
<td></td>
<td>• Catch-up immunizations as needed</td>
</tr>
<tr>
<td></td>
<td>• Dose 3 of the Hepatitis B (HepB) vaccine (if not already received; recommended between ages 6 to 18 months)</td>
</tr>
<tr>
<td></td>
<td>• Dose 4 of the Diphtheria, Tetanus, and Pertussis (DTaP) vaccine (recommended between ages 15 to 18 months)</td>
</tr>
<tr>
<td></td>
<td>• Haemophilus influenza type b (Hib) and Pneumococcal conjugate (PCV) vaccines</td>
</tr>
<tr>
<td></td>
<td>• Dose 3 of the inactivated poliovirus (IPV) vaccines (if not already received; recommended between ages 6 to 18 months)</td>
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<tr>
<td></td>
<td>• Dose 2 of Hepatitis A (HepA) vaccines (recommended between ages 12 to 23 months)</td>
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<tr>
<td></td>
<td>• Yearly flu shot if not already received</td>
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<tr>
<td></td>
<td>• Screenings for TB, developmental health, and oral health as well as a blood lead risk assessment</td>
</tr>
<tr>
<td></td>
<td>• Dental visit as need-identified by child’s doctor**</td>
</tr>
<tr>
<td>18 months</td>
<td>• Well-baby checkup</td>
</tr>
<tr>
<td></td>
<td>• Catch-up immunizations as needed</td>
</tr>
<tr>
<td></td>
<td>• Dose 3 of the Hepatitis B (HepB) vaccine (if not already received; recommended between ages 6 to 18 months)</td>
</tr>
<tr>
<td></td>
<td>• Dose 4 of the Diphtheria, Tetanus, and Pertussis (DTaP) vaccine (if not already received; recommended between ages 15 to 18 months)</td>
</tr>
<tr>
<td></td>
<td>• Dose 3 of the inactivated poliovirus (IPV) vaccines (if not already received; recommended between ages 6 to 18 months)</td>
</tr>
<tr>
<td></td>
<td>• Dose 2 of Hepatitis A (HepA) vaccines (to be taken 6 months after dose 1; recommended between ages 12 to 23 months)</td>
</tr>
<tr>
<td></td>
<td>• Yearly flu shot if not already received</td>
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<tr>
<td></td>
<td>• Screenings for TB, developmental health, autism, and oral health as well as a blood lead risk assessment</td>
</tr>
<tr>
<td></td>
<td>• Dental visit as need-identified by child’s doctor**</td>
</tr>
<tr>
<td>Age</td>
<td>Well-Child Checkups and Shot Guide</td>
</tr>
<tr>
<td>------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
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</tbody>
</table>
| 24 months  | • Well-child checkup  
              • Catch-up immunizations as needed  
              • Yearly flu shot if not already received  
              • Screenings for TB, developmental health, autism, oral health and cholesterol (dyslipidemia), as well as a blood lead risk assessment  
              • Dental visit as need-identified by child’s doctor** |
| 3 years    | • Well-child checkup  
              • Catch-up immunizations as needed  
              • Yearly flu shot if not already received  
              • Screenings for TB, developmental health, autism, oral health and cholesterol (dyslipidemia)  
              • Blood lead risk assessment (if not completed between ages 12 and 24 months)  
              • Dental visit as need-identified by child’s doctor**; may be up to twice a year |
| 4–5 Years  | • Well-child checkup  
              • Catch-up immunizations as needed  
              • Dose 5 of the DTaP vaccine  
              • Dose 4 of the IPV vaccine  
              • Dose 2 of the MMR vaccine  
              • Dose 2 of the VAR vaccine  
              • Yearly flu shot if not already received  
              • Screenings for TB, developmental health, autism, oral health, hearing, vision (between age 4 and 5 years) and cholesterol (dyslipidemia) (if not done at age 3)  
              • Blood lead risk assessment (if not completed between ages 12 and 24 months)  
              • Dental visit as need identified by child’s doctor**; may be up to twice a year  
              • Urine test at age 5 |
<table>
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<tr>
<th>Age</th>
<th>Well-Child Checkups and Shot Guide</th>
</tr>
</thead>
</table>
| 6–20 years (even years) | • Well-child checkup every other year  
• Catch-up immunizations as needed  
• Human papillomavirus vaccine (HPV) at a minimum age of 9  
• Yearly flu shot if not already received  
• Dental visit twice a year  
• Screenings for TB and developmental health  
• Hearing tests at ages 6, 8 and 10  
• Vision screening at ages 6, 8, 10 and 12; follow-up screenings should be done at ages 15 and 18  
• Cholesterol (dyslipidemia) screening at ages 6, 8 and 10, then annually  
• Blood sugar screening beginning at age 10 and continuing every three years when at risk (see below)  
• Blood lead risk assessment at age 6 |
| 11–12 years | • Well-child checkup every other year  
• Catch-up immunizations as needed  
• Human papillomavirus vaccine (HPV) at a minimum age of 9  
• Dose 1 of meningococcal conjugate vaccine (MCV)  
• Tetanus, diphtheria and pertussis (Tdap)  
• Yearly flu shot if not already received  
• Dental visit twice a year  
• STI screening to be performed for sexually active individuals, as appropriate  
• Cervical dysplasia screening for sexually active females*** |
### Age | Well-Child Checkups and Shot Guide
--- | ---
13–14 years (females only) | • Well-child checkup every other year  
• Catch-up immunizations as needed  
• Human papillomavirus vaccine (HPV) at a minimum age of 9  
• Yearly flu shot if not already received  
• Dental visit twice a year  
• Hemoglobin test  
• STI screening to be performed for sexually active individuals, as appropriate  
• Cervical dysplasia screening for sexually active females***

13–17 years (females and males) | • Well-child checkup every other year  
• Catch-up immunizations as needed  
• MCV4 booster (at age 16 years). Tdap if not done previously  
• Human papillomavirus vaccine (HPV) at a minimum age of 9  
• Yearly flu shot if not already received  
• Dental visit twice a year  
• STI screening to be performed for sexually active individuals, as appropriate  
• Cervical dysplasia screening for sexually active females***

18–20 years (up to 21st birthday) | • Well-child checkup every other year  
• Catch-up immunizations as needed  
• Yearly flu shot if not already received  
• Dental visit twice a year  
• STI screening to be performed for sexually active individuals, as appropriate  
• Cervical dysplasia screening for sexually active females***

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

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

***Females should get a pelvic exam and Pap smear between ages 18 and 21; sooner if sexually active.

**For Children With Asthma**

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

**For Children With Diabetes**

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

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

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

- **Blood sugar average** should be done at least yearly. A member’s hemoglobin A1C (HbA1C) should be less than 7%.
- **LDL cholesterol** should be done at least yearly. Treatment may be necessary if LDL results are greater than 100mg/dL.
• **Dilated eye exam** should be done yearly by an eye doctor to check for diabetic retinopathy.

• **Foot exam** should be done yearly.

• **Urine test for protein and microalbumin** should be done yearly to check how well the kidneys are working.

References


ADULT PREVENTIVE HEALTH GUIDELINES

Frequency of Physical Examination

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

- **Ages 18 to 39 years:** Exam frequency: every 1 to 3 years (annual Pap smears are indicated for females unless three consecutive normal smears, allowing Pap smears every 3 years). (Note: In some markets, 21 to 39 years).
- **Ages 40 to 64 years:** Exam frequency: every 1 to 2 years based on risk factors
- **Ages 65 and over:** Exam frequency: every year

<table>
<thead>
<tr>
<th>Age</th>
<th>Screening</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescents 18 and older</td>
<td>Blood Pressure, Height, Body Mass Index (BMI), Alcohol Use</td>
<td>Annually, 18–21 years; after 21, every 1–2 years or per PCP recommendations</td>
</tr>
<tr>
<td>Adults 21 and older</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults 21 years of age and older, especially if at high risk</td>
<td>Cholesterol</td>
<td>Every 5 years (More frequent if elevated)</td>
</tr>
<tr>
<td>Women 21 years of age and older</td>
<td>Pap smear and Chlamydia</td>
<td>Every 1–3 years or per PCP’s recommendations</td>
</tr>
<tr>
<td>Women 40 years and older</td>
<td>Mammography</td>
<td>Every 1–2 years</td>
</tr>
</tbody>
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## Age

<table>
<thead>
<tr>
<th>Age</th>
<th>Screening</th>
<th>Frequency</th>
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</thead>
<tbody>
<tr>
<td>50 years and older</td>
<td>Colorectal</td>
<td>Periodically, depending upon test</td>
</tr>
<tr>
<td>50 years and older</td>
<td>Hearing Screening</td>
<td>Periodically</td>
</tr>
<tr>
<td>Women &gt; 65 years old, or &gt; 60 years at risk</td>
<td>Osteoporosis (Bone Mass Measurement)</td>
<td>Every 2 years or per PCP recommendations</td>
</tr>
<tr>
<td>65 years and older, or younger for those that have diabetes or other risk factors</td>
<td>Vision (including glaucoma or diabetic retinal exam, as needed)</td>
<td>Every 2 years for routine exams, or annually if diabetic or other risk factors</td>
</tr>
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</table>

## Immunizations

<table>
<thead>
<tr>
<th>Immunizations</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Haemophilus Influenza type b (Hib)</td>
<td>For eligible members who are at high-risk and who have not previously received Hib vaccine (1 dose)</td>
</tr>
<tr>
<td>Hepatitis A Vaccine (HepA)</td>
<td>All unvaccinated individuals who anticipate close contact with an international adoptee or those with certain high-risk behaviors</td>
</tr>
<tr>
<td>Hepatitis B Vaccine (HepB)</td>
<td>Adults at risk, 18 years of age and older – 3 doses</td>
</tr>
<tr>
<td>Human Papillomavirus (HPV)**</td>
<td>*For eligible members through 26 years of age (three dose series)</td>
</tr>
<tr>
<td>Measles, Mumps, Rubella (MMR)</td>
<td>Adults born during or after 1957 should receive 1–2 doses</td>
</tr>
<tr>
<td>Meningococcal Conjugate Vaccine (MCV)</td>
<td>College freshmen living in dormitories not previously vaccinated with MCV and others at risk, 18 years of age and older – 1 dose. Meningococcal polysaccharide vaccine is preferred for adults aged ≥ 56 years</td>
</tr>
</tbody>
</table>
### Immunizations

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pneumococcal Polysaccharide (PPSV)</strong></td>
<td>65 years of age and older, all adults who smoke or have certain chronic medical conditions – 1 dose, may need a 2nd dose if identified at risk</td>
</tr>
<tr>
<td><strong>Seasonal Influenza</strong></td>
<td>All adults annually</td>
</tr>
<tr>
<td><strong>Tetanus-Diphtheria and Acellular Pertussis (Td/Tdap)</strong></td>
<td>18 years and older, Tdap: Substitute 1-time dose of Tdap for Td then boost with Td every 10 years</td>
</tr>
<tr>
<td><strong>Varicella (VZV)</strong></td>
<td>All adults without evidence of immunity to varicella should receive 2 doses of single-antigen varicella vaccine if not previously vaccinated or the second dose if they have received only 1 dose</td>
</tr>
<tr>
<td><strong>Zoster</strong></td>
<td>Age 60 and older – 1 dose</td>
</tr>
</tbody>
</table>

### Prevention

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

### Counseling

- Calcium Intake: 1,000mg/day (women ages 18–50 years old), 1200–1500 mg/day (women > 50 years)
- Folic Acid: 0.4 mg/day (women of childbearing age); women who have had children with Neural Tube Defects (NTD) should take 4 mg/day
- Miscellaneous Topics: tobacco cessation, drug/alcohol use, STDs/HIV, nutrition, breastfeeding (for pregnant women) physical activity, sun exposure, oral health, injury prevention, medication lists and poly-pharmacy, and advance directives
References


Always talk with your doctor(s) about the care that is right for you. This material does not replace your doctor’s advice. It is based on third-party sources. We are presenting it for your information only. It does not imply that these are benefits covered by ‘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 doctor right away in a health emergency.
ADVANCE DIRECTIVES

Your Care Is Your Decision

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

Advance Directives Help You Make Your Wishes Known

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

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

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

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

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

Where can I get an advance directives form?

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

How can I learn more about advance directives?

Customer Service can help you learn more. Call toll-free at 1-888-846-4262. TTY users may call 711. A representative will help you sign up for a free educational session. You can also ask your provider for more information.
Can I change my advance directive?
Yes, you can change your advance directive whenever you want. You may want to contact a lawyer for help. It is a good idea to look over your advance directives from time to time. Make sure they still say what you want and that they cover all areas.

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

Do my caregivers have to follow my advance directives?
Yes, as long as your advance directives follow state law. A caregiver may not follow your wishes if they go against his or her conscience. (This means it is possible that a specific treatment or medication you list in your advance directive may be denied to you because the provider cannot in good conscience authorize it.) If so, he or she 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. Any reports of non-compliance can be filed with the Office of Health Care Assurance:

| Department of Health, Office of Health Care Assurance |
| Medicare Section |
| 601 Kamokila Blvd., Suite 395 |
| Kapolei, HI 96707 |
| Phone: 1-808-692-7420 |
| Fax: 1-808-692-7447 |
MEMBER GRIEVANCE AND APPEAL PROCEDURES

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

This section will explain how you can express your concerns.

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

Grievances

What is a grievance?

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

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

How do I file a grievance?

You can file a grievance at any time. You or another person can file a grievance by calling or writing to us. Your doctor or another provider can also file a grievance for you if you authorize them to do so. To authorize your provider to file your grievance. You must send your authorization in writing.
When can I file a grievance?
You can file a grievance at any time. Call Customer Service toll-free at 1-888-846-4262. TTY users may call 711. Or write to:


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

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


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

Appeals
What is an appeal?
An appeal is a request you can make when you do not agree with our decision about the healthcare you are getting and/or our timeliness. You can request an appeal when any of the following actions occur:
• If we deny or limit a service you or your doctor asks us to approve
• If we reduce or stop services you have been getting that we already approved
• If we do not pay for the healthcare services you get
• If we fail to give services in the required time frame
• If we fail to give you a decision on an appeal you already filed in the required time frame
• If we fail to give you a resolution on a grievance in the required time frame
• If we do not agree to let you see a doctor that is not in our network and you live in a rural area or in an area with limited doctors
• If you want to dispute a financial liability

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

**How do I file an appeal?**

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

There is only one level of appeal with the Plan.

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

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<th>Send Your Written Appeals Here</th>
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<tr>
<td><strong>For appeal requests for medical services:</strong></td>
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<tr>
<td>‘Ohana Health Plan</td>
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<tr>
<td>Attn: Appeals Department</td>
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<tr>
<td>P.O. Box 31368</td>
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<tr>
<td>Tampa, FL 33631-3368</td>
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<td>Fax to: 1-866-201-0657</td>
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YOUR HEALTH PLAN

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

What if I need an expedited (fast) appeal?

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

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

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

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

What if I would like to submit additional information?

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

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

What if I do not like an appeal decision?

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

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

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

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

**What happens with my medical benefits (services) during the appeal or State administrative hearing process?**

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

- You request that we continue your services.
- Your appeal or request for a State Administrative Hearing is filed in a timely manner, defined as on or before the later of the following:
  - Within 10 calendar days of the date we mailed you the Notice of Adverse Benefit Determination Letter; or
  - The date we planned to stop or reduce your services
- 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.

If our decision on your appeal, or the States’ decision (if you requested a State Administrative Hearing), is to deny the services, we may ask you to pay for the services you received while waiting for the decision.
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 Hawai‘i Department of Human Services (DHS)/Med-QUEST Division (MQD)
You’ll receive paperwork from DHS. It will be sent when it’s time to recertify your eligibility. This paperwork will tell you what you need to do and by what date. Be sure to provide all of the information that’s required.

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

Here are some of the items you may need:
- Your original birth certificate (or a certified copy)
- A picture ID (like a driver’s license)
- Your Social Security number
- Information like your paycheck stub, child support, bank account details and other insurance you may have (through your job)

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

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

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

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

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

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

How Our Providers Are Paid

‘Ohana works hard to give you the care you need. We work with many providers. You may ask how they are paid and if how they are paid will affect how they use referrals. You may also ask if it will affect other services you may need. Call Customer Service for more information.

Evaluation of New Technology

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

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

The review of new technology is done in these areas:

• Behavioral health procedures
• Medical devices
• Medical procedures
• Pharmaceuticals

To learn more, call Customer Service.
Quality and Member Satisfaction Information

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

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

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

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

If you think or know that fraud, waste or abuse has occurred, tell us. We will be able to determine if something is fraud, waste or abuse. Call our 24-hour Fraud Hotline. The toll-free number is 1-866-678-8355. It is private and you may leave a message without leaving your name. If you do leave your phone number, we will call you back. We’ll do this to be sure our information is complete and accurate. You can also report fraud on our website. Submitting a report through the web is private too. Go to www.ohanahealthplan.com.
MEMBER RIGHTS AND RESPONSIBILITIES

As an ‘Ohana member, you have the right:

• To get information about the plan, its services, its practitioners, and its providers.
• Receive information as required by 42CFR438.10
• 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.
• To request to amend or correct your medical records.
• To have your records kept private.
• Receive care that meets the requirements for timely access and medically necessary coordinated care (42CFR438.206 through 42CRF438.210)
• To make your healthcare wishes known by using advance directives.
• To have input in the plan’s member rights and responsibilities.
• To use these rights no matter your sex, age, race, ethnicity, income, education or religion.
• To have all plan employees honor your rights.
• To get healthcare services that are accessible and comparable in amount, duration and scope to those provided under Medicaid FFS and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
• To get appropriate services that are not denied or cut back just because of diagnosis, type of illness or medical condition.
• To get all information in a way that you can easily understand, in alternative formats and in a manner that takes into consideration your special needs.
• To get help in understanding the rules and benefits of the plan.
• To get verbal interpretation services, at no cost. This is for all non-English languages, not just those that are most common.
• To be told that verbal interpretation is available to you – and how to get this service.
• To get information about:
  - The basic features of managed care
  - Who may or may not join the program
  - The plan’s responsibilities for coordination of care in a timely manner in order to make an informed choice (potential members)
• To get a complete description of your right to leave the plan at least once a year.
• To get a notice of any major change in benefits. You must get this at least 30 days before the change is to go into effect.
• To get full information about emergency and after-hours services.
• To get the plan’s policy on referrals for specialty care and other benefits that are not provided by your PCP.
• To have all these rights apply to the person who you legally appoint to make decisions about your healthcare.
• To freely exercise your rights, including those related to filing a grievance or appeal, and that the exercise of these rights will not adversely affect the way you are treated.
• To have direct access to a women’s health specialist within the network.
• To receive a second opinion at no cost to you.
• To receive services out-of-network if the health plan is unable to provide them in-network for as long as the health plan is unable to provide them in-network and not pay more than you would have if services were provided in-network.
• To receive services according to the appointment waiting time standards.
• To receive services in a culturally competent manner.
• To receive services in a coordinated manner.
• To have your privacy protected.
• To be included in service/treatment 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.

Note:

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

1. To the DHS within 120 days of adopting the policy
2. To members before and during enrollment
3. To members within 90 days of adopting the policy with respect to any particular service
You also have responsibilities as a member:

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