PacificSource Coordinated Care Organization (CCO)

Your Oregon Health Plan Coverage

Lane

For members who live in Lane County.
Updated 01/01/2022 OHA Approved 01/11/2022

PacificSource Community Solutions

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You or your representative can get this Handbook at no charge. You can get this handbook in different languages, large print, electronic format, audio tape, oral presentation (face-to-face or on the phone) or Braille. If you would like a different format, please call our Customer Service department at 503-210-2515. The toll-free number is 800-431-4135. Our TTY/TDD number is 711.

We are open:

- October 1 – January 31
  7 days a week
  8:00 a.m. to 8:00 p.m.
- February 1 – September 30
  Monday through Friday
  8:00 a.m. to 5:00 p.m.

If you need another copy of this handbook, you can find it online at CommunitySolutions.PacificSource.com/member or we can mail you an identical copy for free. Please call Customer Service if you need a copy mailed to you. We will mail you a copy within 5 business days of your request. We can also send you a copy electronically, if you approve that, in your preferred language or format.

Si necesita servicios de intérprete, llame al 503-210-2515 o 800-431-4135. Este manual está disponible en español a petición del interesado al 503-210-2515 o gratis al 800-431-4135.

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Nondiscrimination Statement

Do you think PacificSource or a provider treated you unfairly? We must follow state and federal civil rights laws. We cannot treat people unfairly in any program or activity because of a person's:

Age, Color, Disability, Gender Identity, Marital Status, National Origin, Race, Religion, Sex or Sexual Orientation.

Everyone has a right to know about and use our programs and services. We give free help when you need it. Some examples of the free help we can give are:

Certified and qualified spoken language and sign language interpreters, Braille, Large print for other languages, Written materials in other languages, Audio and other formats.

Everyone has a right to enter, exit and use buildings and services. They also have the right to get information in a way they understand. We will make reasonable changes to policies, practices and procedures by talking with you about your needs.

To report concerns or get more information, please contact our diversity, inclusion and civil rights executive manager:

Civil Rights Manager

- Email: crc@pacificsource.com
- Phone: 888-977-9299, TTY 711
- Mail: PO Box 7068
  Springfield, OR 97475-0068

Customer Service Department

- Phone: 800-431-4135 Toll free,
  800-735-2900 TTY

You also have the right to file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Contact that office in one of these ways:

Bureau of Labor and Industries Civil Rights Division

- Email: crdemail@boli.state.or.us
- Phone: 971-673-0764
- Mail: Bureau of Labor and Industries
  Civil Rights Division, 800 NE Oregon St.,
  Suite 1045, Portland, OR 97232

Oregon Health Authority (OHA) Civil Rights

- Web: oregon.gov/OHA/OEI
- Email: OHA.PublicCivilRights@state.or.us
- Phone: 844-882-7889, 711 TTY
- Mail: Oregon Health Authority, Office of
  Equity and Inclusion Division, 421 SW Oak
  St., Suite 750, Portland, OR 97204

U.S. Department of Health and Human Services, Office for Civil Rights

- Web: ocrportal.hhs.gov/ocr/
  smartscreen/main.jsf
- Email: OCRComplaint@hhs.gov
- Phone: 800-368-1019 or 800-537-7697 (TDD)
- Mail: 200 Independence Avenue SW, Room
  509F HHH Bldg., Washington, D.C. 20201

You may also fill out and mail the OHP Complaint Form. This form can be found on our website at CommunitySolutions.PacificSource.com/member/documentsandforms.

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call toll-free 800-431-4135, 800-735-2900 TTY.
CommunitySolutions.PacificSource.com/member

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-431-4135, 800-735-2900 TTY.
CommunitySolutions.PacificSource.com/member

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-431-4135, 800-735-2900 TTY.
CommunitySolutions.PacificSource.com/member

繁體中文 **(Chinese):** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-431-4135, 800-735-2900 TTY.
CommunitySolutions.PacificSource.com/member

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-431-4135, 800-735-2900 TTY.
CommunitySolutions.PacificSource.com/member

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-431-4135, 800-735-2900 TTY.
CommunitySolutions.PacificSource.com/member

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-431-4135, 800-735-2900 TTY.
CommunitySolutions.PacificSource.com/member

日本語 **(Japanese):** 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます 800-431-4135, 800-735-2900 TTY.まで、お電話にてご連絡ください
CommunitySolutions.PacificSource.com/member

العربية (Arabic): ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 5314-134-008, 0092-537-008 TTY: والبكم الصم ه
CommunitySolutions.PacificSource.com/member

ภาษาไทย **(Thai):** เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 800-431-4135, 800-735-2900 TTY.
CommunitySolutions.PacificSource.com/member

Română (Romanian): ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 800-431-4135, 800-735-2900 TTY.
CommunitySolutions.PacificSource.com/member

ខ្មែរ **(Cambodian):** ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដាយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-431-4135, 800-735-2900 TTY.។
CommunitySolutions.PacificSource.com/member

Cushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-431-4135, 800-735-2900 TTY.
CommunitySolutions.PacificSource.com/member

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-431-4135, 800-735-2900 TTY.
CommunitySolutions.PacificSource.com/member

فارسی (Farsi): توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما 800-431-4135, 800-735-2900 TTY.
CommunitySolutions.PacificSource.com/member

Français (French): ATTENTION: Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 800-431-4135, 800-735-2900 TTY.
CommunitySolutions.PacificSource.com/member

Welcome to PacificSource, Your Oregon Health Plan Health Insurance

Quick Start 1-2-3-4-5!

1. Get connected with a doctor.

- Check to see who is listed as the primary care provider (PCP) on your PacificSource Community Solutions welcome letter included with your member ID card.
- If you already know this doctor and want to keep seeing them, call their office for an appointment the next time you need care.
- If you want to see another doctor, call PacificSource Customer Service to change your PCP. You can also find instructions on how to change this online at CommunitySolutions.PacificSource.com.
- If you don't know this doctor but want to see them, call to schedule an appointment. Tell the receptionist that you are a new member with PacificSource Community Solutions.

2. Get connected with a primary care dentist (PCD).

Call the dental care organization listed on your welcome letter included with your member ID card to find out what dentist you can see for care.

- If you want to change your dentist, ask the dental care organization when you call. If they can't help you, call PacificSource Customer Service at:

  – 800-431-4135 Toll-free

  – 711 TTY

  – October 1 – January 31
  7 days a week 8:00 a.m. to 8:00 p.m.

  – February 1 – September 30
  Monday through Friday, 8:00 a.m. to 5:00 p.m.

- If it's been more than a year since you saw a dentist, call your dentist to schedule an appointment for a dental cleaning and examination.
- If you saw a dentist recently, mark your calendar and call 3 months before your next yearly appointment is due.

3. Tell the Oregon Health Plan (OHP) if you change your phone, address, or name.

- In about a year from your start date, the Oregon Health Plan will request additional information from you to renew your benefits. You will need to send in that information to stay on OHP.
- All paperwork will be mailed to your address on file and cannot be forwarded. Tell Oregon Health Plan about changes to your name, address, or phone by calling 800-273-0557.

4. The benefits chart included in this handbook lists the services our plan covers.

These services are subject to your eligibility for OHP, prior authorization requirements, and where your condition ranks on the Prioritized List of Health Services. Prioritized List of Health Services is a list of covered conditions and treatments.

- See the list here: https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Prioritized-List.aspx.
- Some services need to be approved in advance (preapproved) by PacificSource Community Solutions. Call Customer Service if you need more information about which services are covered and if they need to be preapproved. They can also help you find out if your service has been approved.
- Unless otherwise noted, you must see a PacificSource Community Solutions network provider for these services. We cannot reimburse you for services you pay for out of pocket.

5. All benefits we offer are listed in this book. Some of them may not apply to you.

Please see your Oregon Health Plan (OHP) coverage letter to see what applies to you.

Important Telephone Numbers and Contact Information

PacificSource Customer Service

We are here for you. If you have any questions or need help with how to use your benefits or coordinate your care, please contact us.

Mailing Address:
PacificSource Community Solutions
PO Box 5729
Bend, OR 97708-5729

CommunitySolutions.PacificSource.com

Building Location:
2965 NE Conners Avenue
Bend, OR 97701

Customer Service Department:
503-210-2515 Local
800-431-4135 Toll-free
711 TTY
541-322-6423 Fax

October 1 to January 31:
We are open 7 days a week from 8:00 a.m. to 8:00 p.m.

February 1 to September 31:
We are open Monday through Friday from 8:00 a.m. to 5:00 p.m.

We are closed on the following holidays:

- New Years Day
- Memorial Day
- 4th of July
- Labor Day
- Thanksgiving Day and the day following
- Christmas Day

24-Hour NurseLine

You can call our free 24-Hour NurseLine any time of the night or day to get health information:
855-834-6150 Toll-free
844-514-3774 TTY

Give us a call if you:

- Need help picking a primary care provider (PCP).
- If you are a new member and you need to get medical care or prescriptions right away.
- Need to change your PCP.
- Need to change your dental plan.
- Care while you change plans. (See page 31 for more information.)
- If you need care while you change plans, please call 800-431-4135 or visit
- CommunitySolutions.PacificSource.com. Learn more about this special type of continued care in our Transition of Care policy at: CommunitySolutions.PacificSource.com/Member/DocumentsAndForms.
- Have questions about a medical bill.
- Have questions about what healthcare is covered.
- Need a new member ID card.
- Have a complaint about PacificSource or about healthcare services that you received.
- Need transportation to or from a healthcare appointment.

Dental Plans Customer Service

PacificSource dental health benefits are provided through our partner dental care plans which are also called dental care organizations (DCOs). PacificSource Community Solutions works with three dental care plans:

Advantage Dental Services Customer Service:
866-268-9631 Toll-free (answered 24 hours, 7 days a week for dental emergencies)
711 TTY
AdvantageDentalServices.com

Capitol Dental Care Customer Service:
800-525-6800 Toll-free (answered 24 hours, 7 days a week for dental emergencies)
711 TTY
CapitolDentalCare.com

ODS Community Dental Customer Service:
800-342-0526 Toll-free
711 TTY
ODSCommunityDental.com

Community Mental Health Programs

Lane County Behavioral Health
2411 Martin Luther King Jr Blvd.,
Eugene, OR 97401
541-682-3608 Local
711 TTY

Oregon Health Plan Customer Service

800-699-9075 Toll-free
711 TTY
Oregon.gov/OHA/HSD/OHP/Pages/OHP-Contacts.aspx

Client Services
800-273-0557 Toll-free
711 TTY

Contact OHP Customer Service at 800-699-9075 if you:

- Have questions about eligibility.
- Become pregnant or your pregnancy ends.
- Need to change your mailing address, email address or phone number.
- Report any other household changes.

Contact OHP Client Services at 800-273-0557 if you:

- Want to change your coordinated care organization (CCO) or enroll in one.
- Need a new Oregon Health ID card or client handbook.
- Get a bill and are not in a CCO.
- Need help making an appointment and are not in a CCO.
- Have questions about coverage and are not in a CCO.

Transportation Services

RideSource
9:00 a.m. – 5:00 p.m., Monday – Friday
541-682-5566 Local
877-800-9899 Toll-free
711 TTY

For more information please call Customer Service toll-free at 800-431-4135 or go to CommunitySolutions.PacificSource.com/OregonCCO/Lane and click on the Medical Transportation tab.

Benefits Chart

Benefits may be covered without a prior authorization for medical necessity and with an in-network provider at no charge to you. Out of network services always need a prior authorization unless otherwise noted. For more information please call the number on your ID card.

Alternative Care	Approval or referral needed?	Are there limits to care?
• Acupuncture • Chiropractic • Massage • Yoga	Some services need to be approved in advance. Please call Customer Service to find out what services need approval in advance.	Alternative care services are limited to treatment of a covered illness or injury. Visits are limited to a combined total of 30 visits of alternative care and traditional therapies (see pages 21 & 24.)
Ambulance Services	**Approval or referral needed?**	**Are there limits to care?**
	No approval is needed for emergency transportation.	We cover ambulance services for one-way transportation during emergencies only. We also cover non-emergent medical transportation (NEMT) ambulance service.
Behavioral and Mental Health Services	**Approval or referral needed?**	**Are there limits to care?**
We cover: • Case management, • Emergency services, • Assessments, • Hospitalization, • Medication management, • Programs to help with daily and community living, • Psychiatric residential and day treatment, • Counseling, • Outpatient behavioral health services, • Behavioral health peer delivered services,	No referral is required for behavioral health services. Some services may require approval but most do not. Contact Customer Service for details.	There are no limits on behavioral health benefits.

• Behavioral health assessment and evaluation services (includes Assertive Community Treatment services), • Medication assisted treatment of substance use disorders, • Assertive Community Treatment and wraparound services		
Care Coordination	**Approval or referral needed?**	**Are there limits to care?**
	No approval/referral required.	No limits care.
Case Management Services	**Approval or referral needed?**	**Are there limits to care?**
See page 38 and the Behavioral Health section of benefit chart	No approval/referral required.	No limits care.
Children's Care (age 20 and younger)	**Approval or referral needed?**	**Are there limits to care?**
Eye Care and Eyeglasses	No approval/referral required for eye care appointments. Some eye care products/items require prior authorization.	• There is no limit to coverage of eye exams and new glasses if they are medically necessary. • OHP will pay for contact lenses for only a few conditions.
Newborn Care	No approval/referral required for office visits. Some services/procedures require prior authorization.	Your baby has medical coverage until his or her first birthday, even if you are no longer on OHP.
Shots	• Some shots need to be approved in advance. • You do not need a referral.	• Certain shots are covered for children. (Shots for travel are not covered.) • You can see any provider who will bill us for this service.
Well Child Visits	No approval/referral required.	• From birth to age 36 months, your child is covered for thirteen visits. • From age 3 to 18, your child is covered for one visit a year.
Comfort Care Services	**Approval or referral needed?**	**Are there limits to care?**
See pages 32 and 52 and Hospice section of benefit chart).	No approval/referral required.	No limits care.
Death with Dignity (assisted death for terminally ill)	**Approval or referral needed?**	**Are there limits to care?**
Covered by the OHP.	Services must be performed by an attending physician or consulting physician.	Covered Services include: • Mental health evaluation and counseling. • Prescription medications.

Diabetes Prevention Program	Approval or referral needed?	Are there limits to care?
This program helps those with prediabetes to reduce the risk of type 2 diabetes and improve overall health.	No approval/referral required.	This program is available online or in person in a group setting.
Diagnostic Radiological Services and Medical Studies	**Approval or referral needed?**	**Are there limits to care?**
Exams, such as MRIs and PET scans	Some exams need to be approved in advance.	Unlimited if medically necessary.
Lab Services	Specialized labs may need to be approved in advance. They must be ordered by your PCP or treating specialist.	Unlimited if medically necessary.
X-ray Services	No approval/referral required. They must be ordered by your PCP or treating specialist.	Unlimited if medically necessary.
Dialysis	**Approval or referral needed?**	**Are there limits to care?**
	No approval or referral is needed.	Unlimited.
Drug and Alcohol Treatment	**Approval or referral needed?**	**Are there limits to care?**
We cover: • Assessment/ evaluation services • Case management • Emergency services • Hospitalization • Detoxification • Residential and day treatment • Medication management • Counseling/Outpatient drug and alcohol services • Office visits and treatment	No referral is required for drug and alcohol services. Some services may require approval but most do not. Contact Customer Service for details.	There are no limits on drug and alcohol treatment benefits.
Durable Medical Equipment (DME) and Supplies	**Approval or referral needed?**	**Are there limits to care?**
DME such as: • Medical supplies (including diabetic supplies) • Medical appliances • Prosthetics and orthotics	Some equipment and supplies need to be approved in advance. Please call Customer Service to find out which items need approval in advance. DME may be covered if it is approved for treatment of a covered illness or injury.	The following are some examples of DME covered without approval in advance: • Oxygen and oxygen equipment/supplies. • Some diabetic supplies, such as glucose test strips (subject to quantity limits) with prescription.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Approval or referral needed?	Are there limits to care?
	No approval/referral required.	Unlimited if medically necessary.

Emergency Care	Approval or referral needed?	Are there limits to care?
Emergency Room Visits	No approval/referral required.	We cover emergency care within the United States.

Eye Care	Approval or referral needed?	Are there limits to care?
Benefits for members who are: not pregnant and age 21 and older.	Some services or procedures may require an order from your PCP or specialist and may require approval in advance.	If you have a qualifying medical condition or have been diagnosed with one of the conditions listed below, eye exams and eye glasses may be covered: • Aphakia • Pseudo Aphakia • Keratoconus • Congenital Cataracts • Corneal Transplant

Family Planning	Approval or referral needed?	Are there limits to care?
Family planning is a service to prevent or delay a pregnancy at no cost to you. We cover • Women's health provider, PCP, or other provider for routine and preventive health care servicesBirth control education and counseling. • Contraceptive supplies, such as patches, birth control pills, and intrauterine devices (IUDs). • Emergency contraception (the "morning after" pill). • Sterilization (tubal ligations and vasectomies) when performed by an in-network PacificSource provider. • Radiology services (imaging). • Laboratory testing. Related services that are also covered include: • Pap tests. • Pregnancy tests.	No approval/referral required. This means you have direct access to these services. Some services or procedures require an order from your PCP or specialist. Abortions: Covered by OHP directly (see reference in first column). Please contact the KEPRO Care Coordination Team at (800) 562-4620.	There are no limits when you see any provider that accepts your ID card for this service. IMPORTANT! Hysterectomies are not covered as a part of family planning.

• Screening and counseling for sexually transmitted diseases (STDs), including AIDS and HIV. • Abortions (Contact OHA by visiting Oregon.gov/OHA/PH/HealthyPeopleFamilies/ReproductiveSexualHealth/OregonContraceptiveCare/pages/index.aspx#abortion)		
Hearing Exam	**Approval or referral needed?**	**Are there limits to care?**
	No approval/referral required.	In a 12-month period, you are eligible for: • One basic hearing test. • One comprehensive hearing test. • One hearing aid evaluation and selection. • One electroacoustic evaluation for hearing aid: for one or both ears. • One pure tone hearing (threshold) test; air bone.
Hearing Aids	**Approval or referral needed?**	**Are there limits to care?**
	Services must be approved in advance. Adults: If you meet prior authorization requirements, you may be covered for one hearing aid for each ear every five years. Children through age 20: If you meet prior authorization requirements, you may be covered for one hearing aid for each ear every three years.	We cover up to 60 hearing aid batteries per hearing aid, every 12 months. For hearing aid batteries to be covered, you need to meet the hearing aid prior authorization requirements.
Home Healthcare	**Approval or referral needed?**	**Are there limits to care?**
Examples include: home health aide services, occupational therapy, physical therapy, skilled nursing, speech therapy.	With in-network providers, does not need approval in advance.	Unlimited.
Home Visits	**Approval or referral needed?**	**Are there limits to care?**
(see Home Healthcare in section in benefits chart)		

Hospice (care for terminally ill)	Approval or referral needed?	Are there limits to care?
	With in-network providers, does not need approval in advance.	Unlimited.
Hospital Care	**Approval or referral needed?**	**Are there limits to care?**
	Some services must be approved in advance for treatment of a covered illness or injury.	Unlimited.
In/Out Patient Hospital Visits	**Approval or referral needed?**	**Are there limits to care?**
(see Hospital Care, Outpatient Behavioral Health and Surgery sections in benefits chart)		
Inpatient Habilitative Hospital Services	**Approval or referral needed?**	**Are there limits to care?**
	Services must be approved in advance.	Some services or items may be limited based on coverage and OHP guidelines.
Inpatient Rehabilitative Hospital Services	**Approval or referral needed?**	**Are there limits to care?**
	Services must be approved in advance.	Some services or items may be limited based on coverage and OHP guidelines.
Intensive Care Coordination Services (ICC)	**Approval or referral needed?**	**Are there limits to care?**
Coordination of special services for members who have special needs or disabilities. See page 37 for more information. These services can help you: • Find a provider who can help with special healthcare needs. • Get an appointment with your PCP or specialist sooner. • Obtain equipment, supplies or services. • Coordinate care with your doctors, community support agencies, and social service agencies.	No approval/referral is required for specialty care visits. Some services or items may require prior authorization.	Some services or items may be limited based on OHP guidelines.
Interpreter Services	**Approval or referral needed?**	**Are there limits to care?**
This is a free service. See page 30 for more information.		

Long-term Care services (covered by OHP)	Approval or referral needed?	Are there limits to care?
For more information, visit this link: https://www.oregon.gov/oha/OEBB/Pages/Long-Term-Care.aspx.		
Maternity Services (Pregnancy care)	**Approval or referral needed?**	**Are there limits to care?**
Prenatal care (care for you before your baby is born)	No approval/referral required.	Unlimited.
Labor and delivery	No approval/referral required.	Unlimited.
Postpartum care (care for you after your baby is born)	No approval/referral required.	Unlimited.
Doula services	See page 41 for more information	See page 41 for more information
Care for your newborn baby	No approval/referral required.	Care until he or she is 1 year old
Eye exams and new glasses	No approval/referral required for eye care appointments during pregnancy. Some eye care products/items do require approval in advance.	Covered for pregnant members age 21 or older
Office Procedures	**Approval or referral needed?**	**Are there limits to care?**
	Some services/procedures must be approved in advance.	Unlimited if medically necessary.
Office Visits	**Approval or referral needed?**	**Are there limits to care?**
(see Office Procedures and PCP and Specialty Care visits sections in benefits chart)		
Outpatient Hospital Services	**Approval or referral needed?**	**Are there limits to care?**
Examples of services: • Chemo (see page 38) • Radiation • Pain Management	No approval/referral required.	Unlimited.
Pain Management	**Approval or referral needed?**	**Are there limits to care?**
	No approval/referral required.	Unlimited.
Physical Therapy/Occupational Therapy	**Approval or referral needed?**	**Are there limits to care?**
	Some services need to be approved in advance. Please call Customer Service to find out what services need approval in advance.	These therapy services are limited to treatment of a covered illness or injury.

	Initial evaluations and re-evaluations do not require prior authorization, but are limited to: • Up to two initial evaluations in a 12-month period. • Up to four re-evaluations in a 12-month period.	Physical therapy and/or occupational therapy visits are calculated on a 12 month calendar year. Therapy visits are limited to a combined 30 visits of traditional and alternative therapy. Additional visits may be approved if medically appropriate. Spinal cord injuries, traumatic brain injuries, or cerebral vascular accidents are not subject to the visit limitations during the first year after an acute injury.

Prescription Drugs	Approval or referral needed?	Are there limits to care?
See the Medications section (page 52) for information.		

Preventive Services	Approval or referral needed?	Are there limits to care?
Annual Physical	You do not need a referral for this service.	Covered once every 12 months.
Colon Cancer Screening	No approval/referral required.	You will need an order from your PCP or specialist. Additional screenings are covered if medically necessary.
Mammograms	No approval/referral required.	You will need an order from your PCP or specialist. Covered once every 12-months for women who are age 30 and older.
Prostate Cancer Screening	No approval/referral required.	Digital rectal exam covered once per year.
Women's routine and preventive healthcare services such as: Pap Tests, Pelvic Exams, and Clinical Breast Exams	No approval/referral required.	Pap Tests: Once every 3–5 years unless you have had an abnormal result or considered high risk (then it's covered based on your doctor's recommendation). Pelvic and Clinical Breast Exams: One exam every 12 months (for women).

Primary Care Provider (PCP) Visits	Approval or referral needed?	Are there limits to care?
	No approval/referral required.	Unlimited office visits. Some procedures/treatments must be approved in advance.
Provider Services	**Approval or referral needed?**	**Are there limits to care?**
Office Visits (see Office Procedures and PCP and Specialty Care visits sections in benefits chart) In/Out Patient Hospital Visits (see Hospital Care, Outpatient Behavioral Health and Surgery sections in benefits chart) Home Visits (see Home Healthcare in section in benefits chart Psychiatric Emergency Services (PES) please see page 34. Rehabilitative Services: • Physical, Occupational and Speech Therapy (see Physical/Occupational Therapy and Speech Therapy sections of the benefit chart) • Behavioral and Mental Health Services (see this section in the benefit chart) • Alternative Care (see this section in the benefit chart).		
Rides to Healthcare Appointments	**Approval or referral needed?**	**Are there limits to care?**
See the Transportation Services section (page 44) for information. This is a free service.	No approval/referral required.	Unlimited.
Self-Referral (Direct Access)	**Approval or referral needed?**	**Are there limits to care?**
You may refer yourself for the following services		
Traditional Health Worker (THW) services	No approval/referral required for either in- or out-of-network providers.	Unlimited.

Sexual abuse exams from	No approval/referral required for either in- or out-of-network providers.	Unlimited.
Covered family planning services	No approval/referral required for either in- or out-of-network providers.	Unlimited.
Behavioral health services	Prior authorization is required for out-of-network providers.	Unlimited.
Health risk screening for Intensive Care Coordination (ICC) services	Prior authorization is required for out-of-network providers.	Unlimited.
Intensive care coordination services	Prior authorization is required for out-of-network providers.	Unlimited.
Sexual Abuse Exams	**Approval or referral needed?**	**Are there limits to care?**
	No approval/referral required for either in or out-of-network providers.	Unlimited.
Shots	**Approval or referral needed?**	**Are there limits to care?**
	You can see any provider that accepts your ID card for this service. You do not need to be referred by your PCP.	Certain shots are covered, like flu and preventive shots. Please call Customer Service if you have questions on which shots are covered. Not covered for travel or employment purposes.
Skilled Nursing Facility	**Approval or referral needed?**	**Are there limits to care?**
	Admission does not require an approval in advance.	• Covered for up to 20 days after a covered hospital stay. • If you are also eligible for Medicare, Medicare may cover additional days.
Speech Therapy	**Approval or referral needed?**	**Are there limits to care?**
	Some services need to be approved in advance. Please call Customer Service to find out what services need approval in advance. These services do not require an approval in advance:	Speech therapy services are limited to treatment of a covered illness or injury. Speech therapy visits are calculated on a 12-month calendar year.

	Up to two evaluations of speech/language in a 12-month period. • Up to two evaluations for dysphagia (difficulty swallowing) in a 12-month period. • Up to four re-evaluations in a 12-month period. • One evaluation for speech-generating/augmentive communication system or device in a 12-month period. • One evaluation per twelve months for human-made voice or voice box device.	Speech therapy visits are limited to a combined 30 visits of traditional and alternative therapy. Additional visits may be approved if medically appropriate. Spinal cord injuries, traumatic brain injuries, or cerebral vascular accidents are not subject to the visit limitations during the first year after an acute injury.
Specialty Care (Office Visits & Clinics)	**Approval or referral needed?**	**Are there limits to care?**
Including second opinions.	No approval/referral required. See sections "Second Opinions" and "Seeing Out-of-Network Providers" for more information.	Office visits are unlimited for a covered condition.
Stop Smoking/Tobacco Cessation Services	**Approval or referral needed?**	**Are there limits to care?**
	No approval/referral required.	We pay for medications to help you stop using tobacco products. We will also pay for counseling sessions over the phone, in person, and in groups. For more information, call our Customer Service at 800-431-4135 or the Tobacco Quitline at 800-784-8669.

Substance Use Disorder Treatment	Approval or referral needed?	Are there limits to care?
See Drug and Alcohol Treatment.	No referral is required for substance use disorder treatment. Some services may require approval but most do not. Contact Customer Service for details.	There are no limits on substance use disorder treatment benefits.
Surgery	**Approval or referral needed?**	**Are there limits to care?**
• Surgical Services • Surgical procedures • Reconstructive surgery	Approval in advance is required.	Proof of smoking cessation or nonsmoking status is required prior to elective surgical procedures.
Telehealth	**Approval or referral needed?**	**Are there limits to care?**
• See the Telehealth Services section (page 40). • This is a free service. • Please contact your doctor's office or Customer Service for more information.	No approval/referral required.	Unlimited.
Urgent Care Services	**Approval or referral needed?**	**Are there limits to care?**
Urgent Care Visits	No approval/referral required.	Services are covered 24-hours a day, 7 days a week, at home or if you are traveling outside the service area within the United States.

Dental Services

Some services may need to be approved in advance. Dental services need to be dentally necessary to be covered. For more detailed information on your dental benefits, call your dental plan, which is listed on the front of your member ID card. Going to a specialist without a referral from your primary care dentist (PCD) could result in your bill not being paid by PacificSource Community Solutions. Don't pay provider bills without calling us first.

	OHP Supplemental (For pregnant woman and members under age 21)	**OHP** (For all other adults)
Dental Emergency Services		
Emergency Stabilization Examples: • Extreme pain or infection • Bleeding or swelling • Injuries to the teeth or gum	Yes	Yes
Dental Preventive Services		
Exams	Yes	Yes
Cleaning	Yes	Yes
Fluoride Treatment	Yes	Yes
X-rays	Yes	Yes
Sealants	Yes	Not Covered
Dental Restorative Services		
Fillings	Yes	Yes
Partial Dentures	Yes (with limitations)	Yes (with limitations)
Complete Dentures	Yes (with limitations)	Yes (with limitations)
Crowns	Yes (with limitations)	Yes (with limitations; stainless steel)
Oral Surgery and Endodontics		
Extractions	Yes	Yes
Root Canal Therapy	Yes (with limitations)	Yes (with limitations)
Dental Prescription Medications		
OHP covers formulary prescription medications ordered by an OHA contracted dental provider.		

Getting Care When You Need It

PacificSource Community Solutions works with the State of Oregon to bring you health insurance. It is for people enrolled in the Oregon Health Plan (OHP) who live in Lane County.

Your Member Handbook

Please read this handbook and keep it so you can look at it later if you have questions. This handbook helps you understand the Oregon Health Plan insurance that you have with PacificSource Community Solutions.

When this book says, "PacificSource;· "we," "us;· "our;' "the plan," or "our plan" it means PacificSource Community Solutions.

What Is the Oregon Health Plan?

The Oregon Health Plan (OHP) is a program that pays for low-income Oregonians' healthcare.

The State of Oregon and the US Government's Medicaid program pay for it. OHP covers doctor visits, prescriptions, hospital stays, dental care, mental health services, help with addiction to cigarettes, alcohol and drugs, and free rides to covered healthcare services. OHP can provide hearing aids, medical equipment and home healthcare if you qualify.

CAWEM (Citizen Alien Waived Emergency Medical) covers emergency services for non-US citizens. CAWEM Plus also covers childbirth. To find out which benefits you qualify for, please read your OHP coverage letter or call OHP at 800-699-9075.

What Is Managed Care and Fee-for-Service?

CCOs (Coordinated Care Organizations) are a kind of managed care. The Oregon Health Authority (OHA) wants people on OHP to have their healthcare managed by private companies set up to do that. OHA pays managed-care companies a set amount each month to provide their members the healthcare services they need. Most OHP members must receive managed medical, behavioral health, and dental care.

Health services for OHP members not in managed care are paid by OHA, called open card, or Fee-for-Service (FFS). OHP American Indians, Alaska natives, tribal members, and Medicare members on OHP can ask to get managed care or have an open card. Any CCO member who has a good reason to have an open card can ask to leave managed care. Talk to your provider or caseworker about the best way to get your medical care. If you don't have a caseworker, call OHP at 800-273-0557

What Is PacificSource Community Solutions?

PacificSource Community Solutions is a coordinated care organization (CCO). We are a group of healthcare providers who work together for people on OHP in our community. We coordinate care with other community organizations to meet our member's needs.

With a CCO, you can get all of your healthcare services—medical, dental, and mental—from the same plan.

American Indians, Alaska natives, and tribal members can choose to be enrolled in a CCO like PacificSource. They may also choose to get their healthcare services from a tribal clinic/ Indian Health Services. They can also have OHP Fee-for-Service pay the bills without enrolling in a CCO. These members may be referred by out-of-network Indian Healthcare providers to a network provider without prior authorization

or referral from PacificSource. Members can use both Indian Health Services (IHS) clinics or the Native Rehabilitation Association of the Northwest (NARA). Tribal clinics can also refer members to NARA if needed. Please talk to your caseworker or enrollment assister about the best way to receive your healthcare. You can also call OHP at 800-273-0557.

Community Advisory Council (CAC)

Each coordinated care organization has its own community advisory committee, which is also called the community advisory council (CAC). It is made up of members like you, providers, and other community members. Our Council gives advice and tells us about member and community needs.

The Council lets you have a say in the health plan. Most Council members (more than half) are PacificSource Community Solutions members. The Council gives you the chance to help improve your own health, and the health of your family and community members.

Our Council works to make the services we offer members better. The Council finds ways to improve and gives us ideas about our programs.

The Council helps us respond to members' needs and plan for community health. It helps us with preventive care and strategic planning.

The Council also oversees a Community Health Needs Assessment and a Community Health Improvement Plan.

How to Join the CAC

Members of the CAC are asked to join and to represent the diversity of the Lane county community. For more information about joining, visit CommunitySolutions.PacificSource.com/OregonCCO/Lane and click on the Community Advisory Council tab.

What Is a Patient-Centered Primary Care Home (PCPCH)?

A patient-centered primary care home (PCPCH) is a healthcare clinic that focuses on the patient or member. It includes different providers all in one place. This helps make sure all your medical and mental health needs are met. You can ask at your clinic or provider's office if it is a PCPCH. If you need help finding a PCPCH, please call our Customer Service team.

The Provider Directory

The Provider Directory is a list of all of the doctors, hospitals, and other facilities who we contract with. For the most up to date list, you can call Customer Service toll-free at 800-431-4135 or go to CommunitySolutions.PacificSource.com to search.

If it is not clearly noted in this handbook, the services you get must be from an in-network provider. An in-network provider is someone who has agreed to work with PacificSource Community Solutions. What we pay them for services is enough to cover the entire bill. This means that no other bills will be sent. In some cases, you may have to pay for services, but not usually. For more information on when you may have to pay, see the Billing Information section (page 54) in this handbook.

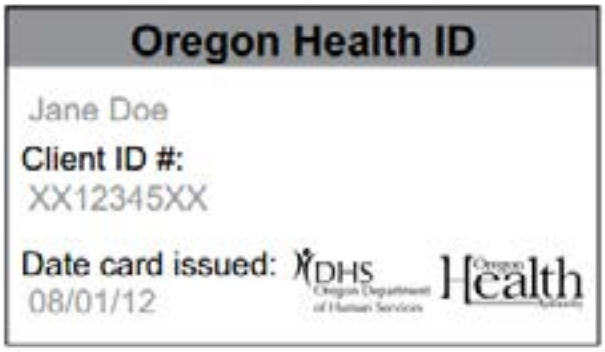
If your doctor is not in the Provider Directory, they are likely an out-of-network (noncontracted) provider. An out-of-network provider is a provider who has not agreed to work with us. They normally do not accept what we pay them for services as payment in full.

If you need another Provider Directory, want to check and see if a provider is in-network and taking new patients, or if you would like to get it in another format (such as other languages, large print, or braille) free of charge, you can call Customer Service toll free at 800-431-4135. You can check our online directory at https://www.communitysolutions.pacificsource.com/tools/providerdirectory.

Your Member ID Card

When you first get benefits, you will be sent two member ID cards within 14 days.

Keep your Oregon Health Plan card in a safe place. This is what your OHP card looks like.



This is what your PacificSource Community Solutions ID card could look like. It is a sample. Keep this ID card with you at all times.

You need to have your ID card with you when you go to healthcare appointments and to pick up drugs at the pharmacy. If you have another insurance carrier, please show them that card as well.

Call Customer Service if you lose your member ID card and we will send you another one.

OHP Coverage Letter

OHP will send you a letter for everyone in your family when you first get coverage. Save this letter in a safe place at home.

The letter tells you your:

- Caseworker name and phone number
- Covered Benefits
- Copay (if any)
- Your assigned coordinated care organization (CCO) such as PacificSource Community Solutions.

OHP will send you a new coverage letter if you ask for one or if your coverage changes. If you have questions about this letter, please call OHP Customer Service at 800-699-9075.

If You Are Pregnant or Have a Newborn

As soon as you know you're pregnant:

Call your caseworker or enrollment assister. They will make sure you don't lose your Oregon Health Plan benefits while you are pregnant.

1. If you don't have a caseworker or enrollment assister, call OHP Customer Service at 800-699-9075.
2. Make an appointment to see a doctor or midwife who takes care of you during your pregnancy. If you do not know who you want to take care of you, call your doctor or clinic, your county public health department, or PacificSource Customer Service toll-free at 800-431-4135 for help.
3. Make an appointment to see a dentist as early in the pregnancy as you can. Keeping your teeth and gums healthy helps you have a healthy birth and will help the baby's teeth and gums be healthy. If you do not know who you want to see, call the Dental Plan listed on your member ID card or call PacificSource Customer Service toll free at 800-431-4135 for help.

As soon as possible after your baby is born:

Call your caseworker, the person helping you sign up, or OHP Customer Service to enroll your baby in OHP. When you call, you will need to provide your baby's:

- Name
- Social Security number
- Date of birth

- Parents' names
- Gender

After you sign up your baby with OHP:

Check your next coverage letter to make sure your baby is listed. If not, call your caseworker, enrollment assister, or OHP Customer Service.

If you don't have a caseworker, call Oregon Health Plan Customer Service at 800-273-0557.

Your Right to an Interpreter

You have the legal right to request a certified healthcare interpreter at your medical appointments. It is also your right to get written material and information in a language you can read and understand. This is a free service. When you call to make an appointment, tell your provider's office that you need an interpreter. Tell them which language you need.

If you need these services in person, you will need to call your provider at least five days before your appointment in most cases. If you need help asking for an interpreter, call Customer Service.

Changing Your Address or Phone Number

If you move or change your phone number, tell your caseworker as soon as possible. If you don't have a caseworker, call Oregon Health Plan Customer Service at 800-273-0557.

Access to Benefits

If at any time your access to benefits change, we will notify you as soon as possible but not later than 30 days from the effective date of the change. If your provider's network status changes and they are no longer in-network, we will make a good faith effort to let you know in writing. We will do this 30 days before the change happens or within 15 days of notice from the provider.

We make sure you are able to get care when you need it. This means immediate assessment and entry for:

- Pregnant women,
- Veterans and their families
- women with children
- unpaid caregivers
- families
- children under 6 years old
- people with HIV/AIDS or Tuberculosis
- people at risk of first episode psychosis and the I/DD population
- IV drug users (including heroin)

For physical health:

- Emergency care is available immediately.
- Urgent care is available within 72 hours.
- Routine visits with your PCP are available within 4 weeks.

For dental care:

- Emergency care is available immediately or within 24 hours.
- Urgent care is available within 1 week for women who are pregnant and within 2 weeks for children and non-pregnant individuals.
- Routine visits are available within 4 weeks, unless there is a special condition. Routine care for pregnant individuals is available within 4 weeks.
- Initial dental screenings are available within 4 weeks.

For behavioral health:

- Urgent care is available immediately or within 24 hours.

- Specialty care is available within 72 hours, unless there is a special condition.
- Routine visits are available within 7 days.

Opioid use disorder:

- Assessment and entry within 72 hours.

Medication assisted treatment:

- As quickly as possible, but not to exceed 72 hours for assessment and entry.
- Care will be provided as soon as possible and may include providing ICC services.

We make sure that you have easy access to the providers. This includes your PCP, OB/GYN, Behavioral Health, Specialists, Hospitals, Pharmacies, and Pediatric Dental providers. We will also make sure these are in a reasonable distance from your home (30 miles or minutes in urban areas, 60 miles or minutes in rural areas).

If you have trouble getting care, please call Customer Service at 800-431-4135 for help.

Care While You Change Plans

Members who change OHP plans can still get the same services and see the same providers. That means care will not change when you switch CCO plans or move from OHP fee-for-service to a CCO. Your new and old plans must work together to make sure you get the care and services you need. This includes:

- Being able to see your previous provider (even if they are not in-network on your new plan)
- Getting medically necessary covered services
- Getting care that was previously approved for you
- Prescription drugs
- Care coordination

If you need care while you change plans, please call 800-431-4135 or visit CommunitySolutions.PacificSource.com. Learn more about this special type of continued care in our Transition of Care policy at: CommunitySolutions.PacificSource.com/Member/DocumentsAndForms.

Medical Benefits

Primary Care Provider (PCP)

When you signed up for PacificSource Community Solutions, we assigned you a primary care provider (PCP). Your PCP or your assigned doctor, is the first doctor you see and the main person who takes care of you. Your PCP works with you to help you stay as healthy as possible. He or she will also keep track of all your basic and specialty care.

Get to Know Your PCP

Check to see who is the primary care provider (PCP) listed on your PacificSource Community Solutions coverage letter. If you already know this doctor and want to keep seeing them, call their office for an appointment the next time you need care. If you want to see another doctor, call PacificSource Customer Service to change your PCP. If you don't know this doctor but want to see them, call to schedule an appointment. Tell the receptionist that you are a new patient to the clinic from PacificSource Community Solutions.

There may be times when you need help getting the right care. Your primary care team may have people specially trained to do this. These people are sometimes called Care Coordinators, Community Health Workers, Peer Wellness Specialists, and Personal Health Navigators.

For more information, please call Customer Service toll-free at 800-431-4135.

Changing Your PCP

If you would like a different PCP than the one on the welcome letter included with your member ID card please call Customer Service. They have the most current information on which providers are adding new patients. To change your PCP, call Customer Service toll-free at 800-431-4135.

Call Customer Service and tell them you want a new PCP. You can change your PCP any time of the month, some exceptions may apply. You will need to talk to your new PCP about any referrals and prior authorizations.

IMPORTANT!

You must call us or visit our website at CommunitySolutions.PacificSource.com when searching for a provider.

After-Hours Care (Evenings, Weekends, and Holidays)

Your PCP looks after your care 24-hours a day, seven days a week. Even if your PCP's office is closed, call their clinic number. There is always an on-call doctor who can help. You can also call our 24-Hour Nurseline for help anytime of the day or night. This phone number is listed on the back of your membership card. If you have an emergency, contact information for Hospitals and Urgent Care services is listed below. You or your representative will get a call back as soon as possible for any urgent or emergent calls. If your call is urgent or emergent, you will receive a call back within 30 minutes. If the information provided does not determine it to be urgent, your call will be returned within 60 minutes to gather more information.

Hospitals

We offer emergency care whenever you need it. You do not need prior authorization to go to a hospital. Hospitals in our service area include:

Sacred Heart University District
1255 Hilyard St
Eugene, OR 97401
541-686-7300 TTY users call 711
PeaceHealth.org/sacred-heart-university-district

Sacred Heart Medical at Riverbend
3333 Riverbend Dr.
Springfield, OR 97477
541-222-7300 TTY users call 711
PeaceHealth.org/sacred-heart-riverbend

McKenzie Willamette Regional Medical Center
1460 G St
Springfield, OR 97477
541-726-4400 TTY users call 711
McKWeb.com

Cottage Grove Community Hospital
1515 Village Dr.
Cottage Grove, OR 97424
541-942-0511 TTY users call 711
PeaceHealth.org/Cottage-Grove-Medical-Center

Peace Harbor Hospital
400 9th St.
Florence, OR 97439
541-997-8412 TTY users call 711
PeaceHealth.org/peace-harbor-medical-center

Urgent Care Services

If you cannot reach your PCP's office about an urgent problem or you cannot get an appointment soon enough, you can go to urgent care. Urgent care services are covered services that are needed right away to prevent your health from getting much worse. This could be a sudden physical or mental illness or an injury..

Urgent care services are covered 24 hours a day, 7 days a week, at home or if you are traveling outside the service area. Urgent care services do not require prior authorization.

You do not need prior authorization to go to urgent care. Urgent care facilities in our service area include:

Nova Urgent Care – Springfield
5781 Main St
Springfield, OR 97478
541-654-0282 TTY users call 711
NovaHealth.com/nova-health-urgent-care

Nova Urgent Care – Pleasant Hill
35859 Hwy 58
Pleasant Hill, OR 97455
541-988-7300 TTY users call 711
NovaHealth.com/nova-health-urgent-care

Nova Urgent Care – Springfield
445 Harlow Rd, Ste 100
Springfield, OR 97477
541-500-6949 TTY users call 711
NovaHealth.com/nova-health-urgent-care

Nova Urgent Care – Eugene
1800 Coburg Rd
Eugene, OR 97401
541-345-8760 TTY users call 711
NovaHealth.com/nova-health-urgent-care

Nova Urgent Care – Eugene
598 E 13th St
Eugene, OR 97401
541-636-3473 TTY users call 711
NovaHealth.com/nova-health-urgent-care

Nova Urgent Care – Cottage Grove
1445 Gateway Blvd
Cottage Grove, OR 97424
541-942-7000 TTY users call 711
NovaHealth.com/nova-health-urgent-care

Nova Urgent Care – Eugene
2710 Willamette St
Eugene, OR 97405
541-735-3161 TTY users call 711
NovaHealth.com/nova-health-urgent-care

Nova Urgent Care – Eugene
4040 W 11th Ave, Ste B
Eugene, OR 97402
458-215-2311 TTY users call 711
NovaHealth.com/nova-health-urgent-care

Nova Urgent Care – Junction City
355 W 3rd
Junction City, OR 97448
541-998-6750 TTY users call 711
NovaHealth.com/nova-health-urgent-care

Nova Urgent Care – Veneta
87983 Territorial Hwy
Veneta, OR 97487
541-935-2200 TTY users call 711
NovaHealth.com/nova-health-urgent-care

Nova Urgent Care – Florence
4480 Hwy 101
Florence, OR 97439
541-997-1251 TTY users call 711
NovaHealth.com/nova-health-urgent-care

Peacehealth Urgent Care – Gateway
860 Beltline Rd
Springfield, OR 97477
541-222-6005 TTY users call 711
PeaceHealth.org/phmg/eugene-springfield/gateway-urgent-care

If You Have an Emergency

Having a medical emergency means you have symptoms that are severe. You believe your health will be in serious danger if you don't get help right away. This can be for your physical or mental health. If you are pregnant, it's an emergency if your unborn child is in serious danger.

An emergency medical condition can also be a serious problem with a part of your body, such as your heart.

Some examples of emergency situations are:

- Broken bones
- Bleeding that does not stop
- Chest pain
- Feeling out of control or like you might hurt yourself or someone else
- Loss of consciousness (passing out)
- Major burns

You do not need prior authorization if you have an emergency. Go to the nearest hospital or call 911 for help.

Emergency services are covered 24 hours a day, 7 days a week.

Remember, whenever you need advice, call your doctor or clinic. Someone will be able to help day and night, 24 hours a day, 7 days a week. They will be able to tell you where to go for care.

We cover ambulance services for one-way transportation during emergencies only. Please call 911 if you require ambulance services.

PacificSource works with your NEMT provider to make sure you can get a ride. If you need a non-emergent ambulance ride, the ambulance company will work with your NEMT provider. The ambulance company will get the records they need about the ride to make sure it is covered.

Post-Stabilization Care

Post-stabilization care is the care you get after an emergency and after your condition is stable. This is available 24 hours a day, 7 days a week. If you get emergency care at a hospital that is out of network and need care after your condition is stable:

- You must return to an in-network hospital to get your care covered, or
- You must get prior authorization in advance to get your care covered.

Call your PCP as soon as you can after your emergency. They will schedule an appointment and decide if you need any more care. Your follow-up care is covered, but is not considered an emergency.

Traveling Out of State

If you are traveling and have an emergency, go to the emergency room or call 911. Emergencies are only covered if it is a true emergency. (OHP does not cover any care in Mexico or Canada). If you don't have an emergency, call our Customer Service department. They will help you get care while you are traveling. Even if we approve a visit while you are traveling, this does not mean that the provider will be willing to bill us for that. This means you could receive a bill for those services. Do not ignore bills from people who treated you

in the hospital. If you get other bills, we will help you. Call PacificSource Customer Service toll free at 800-431-4135 for help.

If you are traveling and need emergency care:

- Make sure you have your ID card with you when you travel.
- Present your card as soon as you can and ask if they are willing to bill us.
- Contact us to discuss the situation and ask for advice on what to do.
- Do not sign any paperwork until you know the provider is willing to bill us.
- If at all possible, have us speak with the providers office while you are there.

Sometimes in an emergency situation, the steps above are not possible. Being prepared and knowing what steps need to be taken can help with billing issues while you are still at the provider's office. We cannot reimburse you for services you pay for out of pocket.

What Should I Do If I Get a Bill?

Call us right away if you get any bills from out of state providers. Some providers send unpaid bills to collection agencies and may even sue in court to get paid. It is much more difficult to fix the problem once that happens. As soon as you get a bill for a service that you received while you were on OHP, you should:

1. Call Customer Service right away and say that a provider is billing you for an OHP service. We will help you get the bill cleared up. Do not wait until you get more bills.
2. If applicable, you can appeal by sending us a letter saying that you disagree with the bill because you were on OHP at the time of the service. Keep a copy of the letter for your records.
3. Follow up to make sure we paid the bill.
4. If you receive court papers, call us right away. You may also call an attorney or the Public Benefits Hotline at 800-520-5292 for legal advice and help. There are consumer laws that can help you when you are wrongfully billed while on OHP.

Prioritized List of Services

As an OHP member, your benefits are based on a list of services. Your conditions and treatments are covered if they are on this list.

You can view the list of covered diseases and conditions. This list is called the Prioritized List of Health Services. It is online at: Oregon.gov/OHA/HPA/DSI-HERC/Pages/Prioritized-List.aspx. The diseases and conditions below the cut-off are not usually covered by OHP. These are called "below-the-line" conditions. This includes diagnosing a condition that is not covered. Once you are diagnosed with a condition that is not covered, OHP will not pay for any more services for that condition.

If you have a condition that is below-the line, OHP will only pay for treatment if it is directly related to another condition that is covered. Your doctor will know if this applies to you.

IMPORTANT!

OHP does not cover everything. Some services (like surgeries and some medical equipment) that are "above-the-line" must meet certain requirements to be covered.

Prior Authorizations

Some services need to be approved by the plan before you get them. This is called prior authorization. In most cases you need to see a contracted or in-network provider for these services. Some treatments at specialist offices must be approved by us in advance.

You can find out if you need prior authorization by calling Customer Service or visiting CommunitySolutions.PacificSource.com.

Specialist Care and Referrals

Referrals are not required from your PCP to see a specialist within your network. If you want to see a specialist outside of your network, this will need to be approved in advance. To get a referral to a provider outside of your network, your PCP or specialty provider may request one or you may also contact Customer Service to request a referral. You also may have visit limits if you are seen for the same condition or diagnosis: this is once every 30 days with your PCP and once every 12 months with a specialist. There may be situations where your condition is not limited to visits.

The following is a list of covered services you do **not** need a referral from your PCP

- Women's exams
- Anticoagulation office visits
- Certain shots
- Dialysis
- Emergency care
- Family planning services (may be given by any provider in or out of network)
- Health department services
- Hospice (care for the terminally ill)
- Intensive Care Coordination (ICC) identified members (including members with special healthcare needs)
- Lactation services (help with breast feeding your baby)
- Members in the special needs rate group A (example: HIV)
- Maternity care (a prior authorization from your PCP is needed to see a specialist other than your maternity doctor)
- Mental healthcare
- Palliative care
- Routine vision exams (only available to children and pregnant women)
- School-based health center services
- Substance use disorder treatment services
- Urgent care

If you have special healthcare needs (SHCNs) or are getting long-term services and supports (LTSS), you have direct access to specialists. You also have direct access for physical health or behavioral health specialists for medically appropriate treatment of your conditions.

Unless noted, you must see a provider that is in the PacificSource network for these services. To find out which providers and facilities are in our network, look in our Provider Directory, or call Customer Service. You can also go to our website CommunitySolutions.PacificSource.com and search for a doctor.

IMPORTANT!

If you see a specialist for a noncovered condition without a prior authorization, the plan may not pay for your care. You may be billed for those services.

Seeing Out-of-Network Providers

You need prior authorization to see out-of-network providers in most cases. There are some exceptions, such as when you need emergency care.

- Your PCP or specialist will send a request to us.
- We will review the request.
- We will send a letter to tell your PCP or specialist if you can see the provider.
- For services approved to a noncontracted provider, we will work with you and your provider so that you can continue to get the services needed until we can find an in-network provider for you.
- You should not be asked to pay any more than if the provider was in-network.

Second Opinions

We cover second opinions at no cost to you. You will need to get a prior authorization if you want to see someone outside of your network. Your PCP or specialty provider may request a second opinion for you. You may also contact Customer Service to request a second opinion for yourself.

Health-Related Services

Staying healthy requires more than good healthcare. Health education, food, shelter supports, and communication services that help you keep in touch with your care team are all key to your health. You can use health-related services to supplement your covered benefits. There are two types of health-related services: Community Benefit Initiatives and Flexible Services.

Community Benefit Initiatives support interventions to improve the health of the community and the quality of healthcare.

Examples of PacificSource Community Benefit Initiates include:

- Supporting programs that use Traditional Health Workers to provide community care coordination for households/people who are struggling to access resources on their own (housing, food, healthcare, employment, etc.).
- Providing free, age-appropriate oral health kits (toothbrushes and fluoride toothpaste) to low-income children.
- Supporting community based programs that encourage academic success and social-emotional development through situational learning and structured programs.

Flexible Services are items or services like a gym membership to help you manage your health conditions, an air conditioner during very hot weather, or emergency housing after hospital discharge. To request a flexible service, contact your healthcare provider. This may be a Primary Care or Behavioral Health Provider, or another provider that helps with your care. If you have questions about flexible services, you may also contact our Health-Related Services team directly at 888-678-0350. Our Care Management Team can also help you work with a provider to submit a request.

If your request for a flexible service is denied, you will get a written notice. If this happens, you can file a grievance (complaint) with your health plan. If the item or service is not approved, you may not appeal or request a hearing.

If you have questions about either community benefit initiatives or flexible services, please contact your healthcare provider or call the PacificSource Care Management Team at 888-970-2507.

Health Risk Screening

We will mail you a health survey when you enroll in our plan and then annually or sooner if there is a change in health status indicating need for an updated assessment. This survey asks about your overall health, health history and other things that may affect your well-being. We will use your answers to connect you with covered benefits, community resources and support your overall care needs. Our care coordinators can even work with your care team – such as a provider, Long Term Support Services case worker, or caregiver – to help coordinate your care. Rest assured, your responses will only be shared with your care team. We will ask your permission before sharing any of your health risk screening information outside of your care team.

This health survey is optional, and it is your choice whether to complete it or not. Simply mark the "I do not wish to complete this survey" and return in the postage-paid envelope.

Intensive Care Coordination (ICC) Services

Intensive Care Coordination Services can help you if you are:

- Identified with special healthcare needs;
- An older adult;

- Blind, deaf, hard of hearing, or have other disabilities;
- Have multiple chronic conditions;
- Have behavioral health concerns including chemical dependency; or
- If you are receiving Medicaid-funded long-term care or long-term services.

ICC helps PacificSource members who are older or have special needs or disabilities to:

- Understand how PacificSource works.
- Find a provider who can help with special healthcare needs.
- Get an appointment with your PCP, specialist, or other healthcare provider sooner.
- Get needed equipment, supplies, or services.
- Coordinate care among your doctors, other providers, community support agencies, and social service agencies.

This is a Direct Access service. This means no prior authorization or referral is needed. If you want to access these services on your own, this is called a self-referral. If you self refer to ICC, an ICC assessment will be conducted.

An Intensive Care Coordination Plan (ICCP) includes all details of the supports, desired outcomes, activities, and resources needed for an individual receiving ICC. This will help you meet and maintain personal goals, health, and safety. It identifies detailed assignments for specific care team members, as well as physical, oral, social, cultural, developmental, behavioral, educational, spiritual, and financial needs to achieve your health and wellness goals.

If you are enrolled in ICC, or a condition-specific program, an ICCP will be created within 10 days of your enrollment. This is updated every 90 days, or sooner if your healthcare needs change. We share the information across your providers and members of your care team to make sure your care is integrated. When ICC services are provided, we ensure that your ICC Care Coordinator's name and telephone number are available to you or your representative.

Call us at 800-431-4135 and we will help put you in touch with a PacificSource staff member who is specially trained to meet your particular need. ICC Services are available Monday-Friday during normal business hours.

Services Covered by OHP

Some benefits are not paid by PacificSource, but are paid by OHP. Transportation for these services is provided through your NEMT benefit.

We can help you get care for some benefits through care coordination. These benefits include:

- Out-of-hospital birth for members with low-risk pregnancies. This includes prenatal and postpartum care
- Certain long-term services and supports
- Certain drugs for some behavioral health conditions
- Therapeutic group homes for members under 21
- Long-term psychiatric care for members 18 or older
- Personal care in adult foster homes for members 18 or older
- If you need services that are not covered by the plan due to moral or religious objections. We do not restrict services for moral or religious reasons.

For more information on the benefits above, or a complete list, call our Customer Service team at 800-431-4135.

There are some benefits that are not paid for by PacificSource, but the KEPRO Coordination Team can help you access them. For more help with these, please call the KEPRO Care Coordination Team at 800-562-4620. These benefits include:

- Physician-assisted suicide
- Abortions
- Hospice for members who live in a skilled nursing facility

- School-based health services that are covered by the Individuals with Disabilities Education Act
- Services provided to Citizen/Alien Waived Emergency Medical (CAWEM) recipients or Children's Health Insurance Coverage (CHIP) for CAWEM
- Certain requested or authorized (approved) administrative exams

If you have any questions about these OHP covered services, you can also call OHP Client Services at 800-273-0557.

Services Not Covered by PacificSource Community Solutions

This is a list of some of the services that are not covered for any member under the Oregon Health Plan. You may be able to pay for some of these services yourself. Please contact Customer Service if you want to receive a complete list of these services.

- Buy-ups (to "buy-up" means you get an item that is not covered by OHP or the plan by paying the difference between the item the plan covers and a more expensive, noncovered model).
- Cosmetic services
- Determined not medically or dentally appropriate
- Determined not to significantly improve the basic health of the member
- Immunizations (shots) for employment or travel
- Most incontinence items, including creams, salves, lotions, barriers (liquid, spray, wipes, powder, paste), devices, or other skin care products
- Lifts (barrier-free ceiling track, chair mechanism, stairs, or van)
- Most personal comfort or convenience items, such as hot tubs, treadmills, whirlpools, Band-Aids®, and bandages, tape, positioning chairs, humidifiers, exercise equipment, cleansers, medical alert bracelets, thermometers, etc.
- Self-help programs (like Alcoholics Anonymous)
- Services received outside the United States, including Mexico and Canada
- Services that are considered experimental or investigational
- Services that need to be approved in advance by PacificSource Community Solutions, and were not preapproved
- Services to help you get pregnant or for treatment of sexual dysfunction, including impotence
- Services covered by other responsible parties (like workers compensation, car insurance, and other coverage)
- Treatment for conditions that are not covered by OHP ("below-the-line")
- Weight loss programs (like Nutrisystem®, Weight Watchers®, and other similar programs)

You may choose to receive noncovered services. However, you will have to pay for them. Before receiving any noncovered service, you and your provider must agree in writing that you will pay for the service.

There are also other benefits that are available directly under OHP, but are not covered under your CCO. We will provide non-emergency transportation to the services covered under OHP described below. Please see transportation services on page 44.

Non-covered health services without care coordination which include, but are not limited to:

1. Physician-assisted suicide under The Oregon Death with Dignity Act;
2. Hospice services for members who reside in a Skilled Nursing Facility;

3. School-Based Health Services that are covered services provided in accordance with Individuals with Disabilities Education Act requirements that are reimbursed with the educational services program;
4. Administrative medical examinations and reports requested or authorized (in accordance with OAR 410-130-0230). An administrative medical examination or medical report may be requested to establish member eligibility for an assistance program or casework planning;
5. Services provided to Citizen/Alien Waived Emergency Medical recipients or CAWEM Plus-CHIP Prenatal Coverage for CAWEM; and
6. Abortions.

For more information on non-covered health services without care coordination, please call the KEPRO Care Coordination Team at (800) 562-4620.

Non-covered health services with care coordination which include, but are not limited to:

1. Out-of-hospital birth (OOHB) services include prenatal and postpartum care for women experiencing low risk pregnancy as determined by the OHA Health Systems Division. OHA is responsible for providing and paying for primary OOHB services including at a minimum, for those members approved for OOHBs, newborn initial assessment, newborn bloodspot screening test, including the screening kit, labor and delivery care, prenatal visits and postpartum care.
2. Long term services and supports. Medicaid-funded long term care services do not constitute health services and are excluded from CCO's reimbursement pursuant to ORS 414.631.
3. Family Connects Oregon services.
4. Assisting members in gaining access to certain behavioral health services.

A few examples of such services include, but are not limited to:

- Certain drugs for some behavioral health conditions;
- Therapeutic group home reimbursement for members under 21 years of age;
- Long term psychiatric care for members 18 years of age and older; and
- Personal care in adult foster homes for members 18 years of age and older.

For more information or for a complete list about these certain behavioral health services, please call Customer Service toll-free at 800-431-4135.

For more information non-covered health services with care coordination, please call Customer Service toll-free at 800-431-4135.

Telehealth

Telehealth is an appointment with a doctor by phone or video. Many providers can connect through a telehealth appointment. This includes medical, mental health, speech therapy, occupational therapy, and physical therapy. Telehealth services save you time. You can also avoid crowds and reduce exposure. Telehealth can be a useful tool for visits, such as follow-ups from prior visits and needing routine prescription fills that require check in.

You may need a smartphone, computer, or tablet to use this. We work with your doctor to make sure that these visits are secure and protect your personal information. We work with your doctor to make sure that these visits are done in a way that ensures you are receiving appropriate access to your healthcare. This includes your preferred format and/or language to ensure it is culturally and linguistically appropriate. If you or your representative require special needs for your telehealth visit, let your doctor know ahead of time, or contact Customer Service toll-free at 800-431-4135.

To find out if your doctor's office is set up for this, call them or check their website. This information can also be found on our Provider Directory online at: CommunitySolutions.PacificSource.com/Tools/ProviderDirectory.

If your doctor offers this type of visit, the Provider Directory will state "This provider offers Telemedicine" under their name. Your provider cannot require that you only use telehealth services. Access to this type of visit varies by provider. Some of these visits may be over phone. Others may require other apps, such as Zoom. If you need help accessing this service, please call your provider's office for assistance. You can also contact our Customer Service team for help at 800-431-4135.

Traditional Health Worker (THW) Services

Traditional Health Workers (THW) are available to help connect you to a broad range of services to support your health and wellness. They provide information, tools, and support. Traditional Health Workers can be found in community-based organizations and in clinics. They have similar life experiences with the people they serve and are trained to know how to support your specific goals.

There are seven different types of THWs that you as a member have access to:

- Birth Doulas: Assist pregnant people and their family with pre-natal, childbirth and post-partum support.
- Personal Health Navigators (PHN): Assists a member in navigating the healthcare system.
- Peer Support Specialists (PSS): Personalized peer support with shared lived experience to offer hope and recovery from addiction/mental health conditions.
- Peer Wellness Specialists (PWS): Personalized peer support with shared lived experience to offer hope and recovery with both addiction/mental health and a physical health condition.
- Community Health Workers (CHW): Supports individuals, families and communities to achieve their health and wellness goals.
- Family Support Specialists (FSS): Personalized peer support with shared lived experience to families parenting a child with complex needs.
- Youth Support Specialists (YSS): Personalized youth to youth peer support to offer hope and recovery from addiction/mental health conditions and other complex life situations.

The Member Support Specialist (MSS) Team at PacificSource has Personal Health Navigators (PHN) who are available to help you:

- Understand how PacificSource works
- Answer questions on your medical, dental, and behavioral health benefits
- Connect to community resources
- Connect to healthcare providers to schedule visits
- Assist with transportation to medical visits

You do not need a referral to speak with a THW. If you want to access these services on your own, this is called a self-referral. If you would like to talk with a THW Liaison, or be connected to THW services in the community or at your provider's office, please call 541-640-8742. If you would like to speak to our MSS Team, they can also be reached at 541-330-2507, or toll-free at 888-970-2507. If your THW Liaison changes, we will let you know by mail.

Care Coordination

We have care coordinators at PacificSource that can help you understand your benefits and how they work. We work with your providers and community partners to make sure your care is coordinated and integrated. This includes behavioral healthcare. Our care coordinators will help you with how to navigate the coordinated care system. You may also access coordinated

care services through your primary care provider, patient-centered primary care home, or other primary care teams.

We will ensure that you can access care coordination, community-based care, and assist you with care transitions in a way that works with your language and culture to reduce the need for hospital and nursing facility visits.

Members that have both Medicaid and Medicare may also request Care Coordination through PacificSource. If you have both Medicaid and Medicare through us, we have a specific Care Coordination team designated to help you navigate your benefits and coordinate your care. This team can also be reached by contacting Customer Service.

If you would like a care coordinator to help you, please call Customer Service at 800-431-4135.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program offers regular physical health and behavioral health screenings for growth & development, and nutritional needs for eligible members (birth through age 20). If you think you or someone in your family may need an EPSDT screening, talk to your provider or call Customer Service and we will help you schedule one.

The EPSDT program:

- Helps children stay well by identifying healthcare needs as early as possible
- Helps children access health, social, educational, or nutritional programs to maintain wellness
- Provides services that are free of charge to the eligible member
- Provides free rides to and from EPSDT services

If you or your child are eligible for EPSDT services and have a primary care provider, EPSDT services will include:

- Notification to the member or member's representative
- Well-child medical exams
- Screening, diagnosis, treatment and referrals for follow-up care when medically appropriate
- Regular dental and oral health services. While required dental or oral health services are not part of the EPSDT program these services will be provided to you. Your EPSDT provider may offer a direct referral to a dentist for dental services. Our Care Management (Care Coordination Team) can also help you access a dentist
- EPSDT will help maintain your health history when information is received from other providers
- EPSDT will help with accessing services. This is for a new physical, behavioral, or oral health issues, or a health issue that is on-going

Many types of providers may offer EPSDT services including:

- Physicians (MDs or DOs)
- Nurse Practitioners
- Licensed Physician Assistants
- Other licensed Professionals (continuing care providers)

To receive EPSDT services, you or your representative will need to sign an agreement with your PCP providing EPSDT services. This agreement says that you will receive EPSDT services from that provider and for how long.

The EPSDT screening must include:

- A complete history (health and development) that includes physical and behavioral health development
- A nutrition assessment
- A complete physical examination including teeth and gums
- Immunization history compared to the recommended immunization schedules:
  - Up through age 18
  - https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html
  - Ages 19 through 20
  - https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html
- Lead testing
- Laboratory tests as needed
- Hearing and vision testing as needed
- Health education
- Recommended ESPDT screening services based on the stage in life, up through age 20
  - Periodicity schedules for screening services:
  - https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf
- EPSDT fact sheet:
  - https://www.oregon.gov/oha/HSD/BH-Child-Family/SOCAC/EPSDT%20fact%20sheet-OR%20Final.pdf
- Covered services found on the OHP Prioritized list of Health Services

If your screening shows you need any of the following services, these must be provided to you:

- Diagnosis and treatment for issues with vision or hearing, including eye glasses and hearing aids
- Dental care (birth through age 20) for:
  - pain, infections
- to fix or replace your teeth (restoration)
  - maintenance
- Immunization(s) will be given at the time of screening, if needed

If, during your screening, your provider finds you need help with a medical, behavioral health, substance abuse, or dental condition:

- You may be referred to a specialist provider for more assessments or treatment of that condition. Your provider will explain what these are and why they are needed
- If you or your representative agree with the plan, you will be offered help in making appointments for the assessments and/or treatment
- If you need or want help, our Care Management (Care Coordination) Team can assist you

EPSDT services will be provided promptly after the request for screening is received, generally within 6 months of the request.

Services not covered under EPSDT include but are not limited to Supplemental Nutrition Assistance Program (SNAP), and other Social Services programs.

For information on what we cover under EPSDT, including transportation and care management (care coordination) services, or for information or referral assistance for treatment and services not covered under EPSDT, call our Customer Service team at at 800-431-4135. You may also visit our website at: CommunitySolutions.PacificSource.com/#

Transportation Services

Getting a Ride to a Healthcare Appointment

RideSource helps Oregon Health Plan (OHP) members get to their healthcare appointments. The program is called Non-Emergent Medical Transportation (NEMT). NEMT is for scheduled healthcare appointments, not emergencies.

There are many ways we can help you get to your appointment depending on your needs. Examples are:

- Bus pass or taxi service.
- A ride from a volunteer driver.
- Wheelchair-accessible vehicle service.
- PacificSource works with your NEMT provider to make sure you can get a ride. If you need a non-emergent ambulance ride, the ambulance company will work with your NEMT provider. The ambulance company will get the records they need about the ride to make sure it is covered.
- Reimbursement for driving yourself.

Please note, some rules may apply.

For more information, call our NEMT Services provider:

RideSource
8:00 a.m. – 5:00 p.m., Monday – Friday
541-682-5566 Local
877-800-9899 Toll-free
711 TTY

For more information please call Customer Service toll-free at 800-431-4135 or go to CommunitySolutions.PacificSource.com/OregonCCO/Lane and click on the Medical Transportation tab.

Who Can Get Free Rides

You can get free rides from your NEMT provider if:

- You are covered by PacificSource insurance through the Oregon Health Plan (Medicaid) in Lane County.
- You are traveling to a covered healthcare appointment or other healthcare service, such as health-related services. For members who have Medicaid and Medicare insurance, the ride can be provided to Medicaid or Medicare covered appointments.
- You need help getting there.

How to Schedule a Ride

Call RideSource as soon as you can. You or your representative can schedule your ride. We prefer that you call to schedule your ride after you have made your appointment with your provider, but it is not required. We will schedule same day transportation, if needed. We will also schedule transportation up to 90 days in advance.

If you have an emergency, call 911. RideSource cannot arrange emergency ambulance rides.

Reimbursements

You can get paid back for your mileage, hotel, and food expenses when you are traveling for covered services. If you want to be reimbursed, you must send required forms to RideSource within 45 days from your appointment. You do not need to call RideSource before your appointment to be reimbursed.

If the ride is urgent and RideSource is closed, you can be paid back for mileage, hotel, and food expenses. Please call the following business day for instructions on how to receive

your reimbursement. Please note, some rules may apply.

Transportation Resources

For additional information regarding transportation and general services you can either reference our website and select your region or we have included the Riders Guide in your New Member Packet, that included your Member Handbook. You will find under Medical Transportation resources online available to you.

- Riders Guide
- NEMT FAQ
- NEMT Flier

You can visit our website at: CommunitySolutions.PacificSource.com/OregonCCO/Lane

Scheduling Free Rides:

You can get a ride for any time and every day of the year. Call your NEMT provider to schedule a ride. You, or someone acting for you, can ask for a ride. Someone acting for you includes a Community Health Worker, foster parent, adoptive parent, or your provider.

Your NEMT provided offers All types of interpreter services, free to you or your representative.

You or your representative can schedule multiple rides for appointments that are recurring up to 90 days in advance. You can schedule a ride after business hours. Call your NEMT provider and choose the phone option for your needs. You can ask for a same day ride, but try to call to set up your ride as soon as possible. Please try to call at least 24 hours before your appointment.

The NEMT provider will work with you to schedule your free ride. When you schedule your free ride timely, the NEMT provider will ask you for the best way to contact you and the best time to contact you.

Please have this information ready when you call:

- Your name, address and phone number (any clear directions to your home or where you are)
- Doctor or clinic name
- Provider's address and phone number
- Referring doctor, if appointment is outside of your local area
- Date and time of your appointment
- Pick-up time after your appointment
- Type of appointment (primary doctor, therapy, behavioral health, etc.)
- If someone will be going with you
- Any mobility needs (such as a wheelchair or service animal)
- Your height and weight for all stretcher and wheelchair rides
- Any details to help us meet your needs (such as car seats, children)

The NEMT provider will try to tell you the ride details when you call to ask for a ride. If they can't, the NEMT provider will call you later to tell you about the details. They will do this before the driver comes to pick you up. The ride details include:

- The name and phone number of the driver
- The time and address for pickup
- The name and address of the health care provider you will be going to You will not be responsible for making the ride details. The NEMT provider will match your ride to the driver that best fits your needs. The driver will work with the NEMT provider to keep track of where they are. They will also help with any pickup or return problems.
- Drivers can't drop you off at your appointment more than 15 minutes before the provider's office opens.

- Drivers can't pick you up more than 15 minutes after the provider's office closes They will only do this if you, your guardian, parent, or representative ask.

- Drivers must drop you off at least 15 minutes before your appointment time. They can't drop you off more than one (1) hour before your appointment. The driver may get there before the scheduled pick-up time. You don't have to get in the vehicle before the scheduled pick-up time.

Member drop-offs and pick-up Special Requests:

- Not permit drivers to drop Members off at an appointment no less than fifteen (15) minutes prior to their appointment time or to the office or other facility opening for business, unless requested by the member or, as applicable, the Member's guardian, parent, or representative; and

- Not permit drivers to pick up Members from an appointment more than 15 minutes after the office or facility minutes after closing, or as requested by the member, or as applicable, the Member's guardian, parent, or representative;

Passenger Rights:

- Receive safe and reliable transportation services that are appropriate for your needs.
- Ask for interpretation services when talking to Customer Service and request materials in a language or format that meets your needs.
- File grievances about your experience.
- Submit an appeal, ask for a hearing, or ask for both if you feel you have been denied a service unfairly.
- Receive a written notice when a ride is denied.

Passenger responsibilities include:

- Treating drivers and other passengers with respect.
- Calling us as early as possible to schedule, change or cancel your transportation.
- Using seat belts and other safety equipment as required by Oregon law.
- Requesting additional stops in advance. If you need to make a stop at a pharmacy or other location, we must approve that.
- Prior to mailing a notice of adverse benefit determination to a member, the CCO must provide a secondary review by another employee when the initial screener denies a ride.
- The CCO must mail, within 72 hours of denial, a notice of adverse benefit determination to:
  - A member denied a ride; and
  - The provider with which the affected member was scheduled for an appointment provided that the provider is part of the CCO's provider network and requested the transportation on the member's behalf.

Complaints (Grievances)

As a user of NEMT services, you or your representative have the right to:

- File a grievance (complaint) with your NEMT provider or PacificSource Community Solutions
- Appeal a denial of a ride You can learn more about how to file a complaint or an appeal in the Member Handbook.
- You also have the right to send a grievance even if it has been submitted before. PacificSource and the NEMT provider can't stop you from making complaints or grievances that have been made previously.

Please see section called Complaints and Appeals, page 61.

Behavioral Health Services

Behavioral Health Services - Treatment for Mental Health and Substance Use Disorders

You do not need to get a referral or an approval from your provider to get these benefits.

Behavioral Health treatment services include:

- Case management
- Consultations
- Counseling
- Crisis services
- Behavioral Health Assessment and Evaluation Services
- Hospitalizations
- Medication management
- Programs to help with daily and community living
- Wraparound or system of care services for children and families (provided through the county Community Mental Health Programs (CMHP))
- Residential and day treatment for children
- Detox and Residential Treatment of Substance Use Disorders
- Medication Assisted Treatment of Substance Use Disorders
- Treatment of Autism (See Applied Behavioral Analysis Therapy on page 48.)
- Assertive Community Treatment (ACT)
- Outpatient Behavioral Health services or Behavioral Health peer delivered services;

You do not need a prior authorization for these services:

- Outpatient behavioral health
- Peer deliver services
- Behavioral health assessment/evaluation
- Assertive Community Treatment (ACT)
- Medication Assisted Treatment (MAT)
- Wraparound

Access to Behavioral Health Services

- You can get help with many mental health concerns. This can be things like depression or anxiety. You can get help with alcohol or drug concerns. The first step is to have a mental health assessment. This will tell us what kind of help you may need. These services are available through the county Community Mental Health Program (CMHP) or available through any in-network provider found in the provider directory, and you have a choice: CommunitySolutions. PacificSource.com/Tools/ProviderDirectory. Our directory is a great tool should you want a second opinion on any behavioral health assessment, evaluation, or service.
- We make sure you have access to services within:

  – 30-miles or 30-minutes for Urban Areas

  – 60-miles or 60-minutes for Rural Areas
- You take priority, and we support your accessing services as soon as possible by monitoring availability for the following needs and timelines:

- Urgent Behavioral Health Crisis:

  – Access Within 24-hours

- PregnantVeteran and/or family of veteran, Woman with children, Unpaid care givers, Families and children ages birth through 5 years, HIV/AIDS or tuberculosis positive, At risk of first episode of psychosis (e.g. seeing or hearing things that others cannot), Intellectual and Developmental Disabilities (I/DD, Intravenous (IV) Drug Use (e.g. heroin)

  – Immediate assessment and entry

- Use of opiates which changes daily functioning

  – Assessment and entry with 72-hours

- Inquiry and Referral to Medically Assisted Treatment (MAT)

  – As soon as possible and less than 72-hours for assessment and entry

- First time requests for behavioral health care (i.e. screening, therapy, someone to talk to)

  – Assessment within 7-days

If we cannot meet these due to lack of available appointments, we support members by providing interim services similar to requested services:

- Referrals and care management
- Methadone Maintenance or MAT
- HIV/AIDS testing
- Outpatient services for substance use disorders
- Withdrawal management
- Other behavioral health services

Phone Numbers for Community Mental Health Program (CMHP)

Lane County Behavioral Health
2411 Martin Luther King Jr Blvd.
Eugene, OR 97401
541-682-3608 Local

Mental Health Assessment and Treatment Planning

Members can get a complete mental health assessment. You can get an assessment from your local CMHP or in-network provider.

You can also get one from an approved primary care clinic that has combined behavioral health services . The full assessment will be used to find out what the right treatment is for you.

How to Change Your Behavioral Health Provider

You can see any behavioral health provider in our network without a referral. Please tell to your current provider if you want to change your behavioral health provider. They will help you to find the best provider for you. You may call our Customer Service team and they can help you make that change if you need help.

Behavioral Health Services in the Primary Care Setting

- You can get routine behavioral health services directly from our in-network providers.
- You don't have to get a referral from your primary care provider (PCP) or a prescreening from our assigned Community Mental Health Program to get routine behavioral health services.
- Many primary care offices have behavioral health services with licensed behavioral health providers.

Applied Behavioral Analysis Therapy

Applied Behavioral Analysis Therapy (ABA) is a service for Autism. The member must have an assessment from a licensed mental health provider before you can be referred to ABA.

ABA has experience and knows how to diagnosis Autism. Please talk to your providers

about getting ABA services or call our Customer Service team for help.

Behavioral Health Crisis Services

Members that need emergency and urgent mental healthcare can call their local community mental health provider (CMHP) to get care. All CMHPs have a crisis phone line that is available 24 hours a day, 7 days a week. You can also call 911.

A crisis is when you're feeling that you need support immediately. Crises can occur at random and may include thoughts of suicide or self-harm. These are covered services that are needed to keep a person's mental health from getting worse. Behavioral health crisis or emergency behavioral healthcare is covered 24 hours a day, 7 days a week. You do not need prior authorization. This includes support (stabilization) services after a Behavioral Health crisis or emergency.

Access to mobile crisis services and the crisis line are available for members to promote stabilization in a community setting rather than arrest, going into an emergency department, or admission to an acute care facility. For members receiving intensive in-home behavioral health treatment, crisis response services are available 24 hours a day.

If you are having a crisis, please call our mental health crisis line.

Crisis line
800-273-8255 National Suicide Prevention
800-221-2832 TTY
Text: 741741

Lane
541-687-4000 Whitebird Crisis Line
541-505-8426 Hourglass Community Crisis Center

Call 24-hours a day, 7 days a week. Or call 911.

IMPORTANT!

You do not need to get prior authorization from us to call the crisis line or to get emergency services. You can use those services at any time you feel you are having an emergency.

Ask your PCP, counselor, therapist, or mental health doctor to make a crisis plan for you. This plan will help you avoid crisis and know what to do in a crisis.

Substance Use Disorder Treatment

You do not need a referral for substance use disorder services. You can see any drug and alcohol treatment provider in our network. If you think you need treatment for a substance use disorder, you can:

- Talk to your PCP
- Contact any in-network provider listed in the provider directory that offers drug and alcohol treatment services
- Call us for help

The plan pays for outpatient office visits, residential treatment, and detoxification when it is considered clinically appropriate.

If you need help for a substance use disorder, you may see any in-network drug and alcohol/substance use disorder treatment provider to be assessed and referred to the appropriate level of care.

Choice Model Services for Mental Health Treatment

Choice Model Services is a program to help adults get better mental healthcare. It helps adults with severe mental illnesses get more and better services in the community. The goal is to keep people healthy in their communities.

Integrated Services Array (ISA) is a program of intensive services for children with mental illness. It aims to keep them safe at home, in school and in their community.

Dental Health Services

Oral health is part of overall health. The Oregon Health Plan covers emergency/urgent, prevention, and treatment services for children and adults. These covered dental services are provided at no cost to you. PacificSource dental health benefits are provided through our partner dental care plans, which are also called dental care organizations (DCOs).

You will find your dental plan on your PacificSource member welcome letter included with your member ID card. Please make sure to show your member ID card each time you go to the dentist. If you cannot find your card or are unsure which dental plan you are on give PacificSource a call and we can help.

Getting Started

Your dental plan will connect you with your regular dentist, also called a primary care dentist (PCD) and other specialty dental providers if needed. Your dental plan can work with you to connect with a dentist who is accepting new patients and is close to where you live or work.

It's a good idea to make an appointment to see your PCD soon after you are assigned to a dental plan. Your PCD can provide your routine, urgent, and emergency care. Don't wait until you have a dental emergency to see your PCD.

PacificSource Community Solutions works with three dental care plans:

Advantage Dental Services
Customer Service:
866-268-9631 Toll-free (answered 24 hours 7 days a week for dental emergencies)
TTY users call 711
AdvantageDentalServices.com

Capitol Dental Care
Customer Service:
800-525-6800 Toll-free (answered 24 hours 7 days a week for dental emergencies)
TTY users call 711
CapitolDentalCare.com

ODS Community Dental
Customer Service:
800-342-0526 Toll-free
TTY users call 711
ODSCommunityDental.com

Changing your Dental Plan

If you didn't choose the dental plan you are assigned to, you may change it. Just give us a call at 503-210-2515 or 800-431-4135. TTY users call 711.

Changing Your Dental Provider

Call your dental plan to make changes to your regular dentist. They will work with you to resolve your concerns or find the best provider for your needs.

How to Make an Appointment

To make an appointment, call your dentists' office. Tell them you are a PacificSource Community Solutions member, which dental plan you are with, and why you want to see a dentist. Remember to take your PacificSource member ID card with you to the appointment. If you need sign language or an interpreter at your appointment, be sure to tell the clinic staff when you make the appointment. This service is free.

Make appointments to see your dentist once or twice per year. They will talk with you about what kind of care you might need, and how often you should see them.

Referrals to Other Providers and Specialists

If you think that you need to see a dental specialist or other dental provider, make an appointment with your PCD first. Your PCD will decide which services and tests you may need.

If you need to see a specialist or other provider, your PCD will refer you. If you go to a provider who is not your PCD or a provider who your PCD has not referred you to, you may have to pay for the care yourself. In an emergency, get help even if you cannot contact your dentist.

Second Opinions

We cover second opinions and services that your PCD does not, at no cost to you. You will need to get a prior authorization if you want to see someone outside of your dental plan's network. Your PCD or specialty provider may request a second opinion for you. You may also contact Customer Service to request a second opinion for yourself.

Getting Urgent or Emergency Dental Care

A dental emergency is when you need immediate care and treatment. An injury or illness may cause a dental emergency.

Emergency dental care is covered 24 hours a day, 7 days a week at home or if you are traveling outside the service area within the United States. This includes any hospital or other setting for emergency care. Emergency services do not require prior authorization.

Examples of dental emergencies include:

- Heavy bleeding that does not stop
- A serious infection
- Severe pain
- A tooth knocked out

If you have a dental emergency, call your dental provider first, even if it's after normal business hours. Someone will be able to talk to you or provide you a way to reach a provider. If you can't reach your PCD or don't have one yet, call your dental plan and they will help you get care.

Urgent dental care is when you need care but it is not as severe as a dental emergency. Examples of urgent conditions are:

- A toothache
- Swollen gums
- A lost filling

We cover ambulance services for one-way transportation during emergencies only. Please call 911 if you require ambulance services. If ambulance services are used for something that is not an emergency, you may have to pay the bill.

Medications

PacificSource Community Solutions Coordinated Care Organization (CCO) lists covered drugs on a formulary (drug list). Pharmacists and providers decide which drugs are on the formulary. This drug list may change throughout the year. Sometimes we add, remove or change the coverage requirements on drugs.

PacificSource covers drugs for conditions on the OHP Prioritized List of covered conditions and treatments. Select over-the-counter (OTC) products and devices are also covered. The covered OTC products are listed on the drug search page of our website. Your pharmacy will need a prescription from your provider before we can pay for an OTC drug.

If you want a copy of the formulary or have questions, call Customer Service. You can also see the covered drugs online at CommunitySolutions.PacificSource.com/Search/Drug.

Filling Your Prescription

We cover both brand name and generic drugs. If a generic drug is available, we will generally not cover a brand name drug. Most drugs are limited to a 31-day supply when filled at contracted retail pharmacies. Birth control can be filled for up to a 12 month supply at a participating pharmacy after you've first filled a 90 day supply of your birth control. You may get up to a 60-day supply of most drugs at our contracted mail-order pharmacy. Select drugs are available in extended day supply (up to 90 days) via mail order. See the restriction section on the website drug search tool for qualifying drugs. Specialty drugs are listed as Tier 3 on the formulary. Tier 3 drugs are limited to a 31-day supply and must be filled at a contracted Specialty Pharmacy.

To fill a prescription, take your prescription and your Oregon Health Plan and PacificSource ID cards to a contracted pharmacy. We contract with the active Oregon Health Authority (OHA) pharmacy network. To locate a contracted pharmacy, use the pharmacy network search on our website or call Customer Service. Prescriptions must be filled at a contracted pharmacy for coverage of the medication. There are few contracted pharmacies or prescribers outside Oregon, therefore, consider using CVS Caremark Mail-Order Services prior to traveling outside of Oregon.

Please call Customer Service before you pay out of pocket for any prescriptions. If you purchase medications outside the area and the prescriber and/ or pharmacy is not contracted, then we will not be able to reimburse you for those prescriptions. Only in some emergency situations will those prescriptions be covered.

Coverage Limitations

These drugs are not covered:

- Drugs not listed on the formulary.
- Drugs used to treat conditions that are not covered by the Oregon Health Plan. Some examples of not covered conditions are fibromyalgia, hay fever, and rashes.
- Drugs used for cosmetic purposes.
- Drugs that are not approved by the U.S. Food and Drug Administration (FDA).
- Drugs that are being studied and are not approved for your disease or condition. A drug may be approved by the FDA for use with one or more conditions but not approved for other conditions.
- Drugs covered by the state on the 7-11 or Carve Out Drug list for mental health conditions.

- Drugs covered by Medicare Part D plans for eligible members. For Medicare eligible members, Medicaid does NOT pick up Part D eligible drug costs, including copays or co-insurances. If you do not elect Part D coverage, you are responsible for your drug costs.

Some drugs on the formulary have requirements or limits on coverage. These may include:

- Using generic drugs when they are available
- Age restrictions
- Quantity limits
- Prior authorization
- Step therapy

Mental Health Medication

Mental health prescriptions are billed by pharmacies directly to Oregon Health Authority (not to PacificSource Community Solutions).

When you go to the pharmacy, please show them your Oregon Health Plan ID card. Be sure to tell them you are a PacificSource Community Solutions member. They will know where to send the bill.

How to Team Up with Your Provider

Providers are encouraged to prescribe drugs that are on our formulary list. Drugs that are not on the formulary are called "nonformulary." Those drugs are not covered unless PacificSource gives an exception.

If your provider feels you should get a drug that is not on the list, he or she may ask for prior authorization. The request must tell us why other medications are not a good choice for you. Once we review the request, we will tell you and your provider in writing of our decision. A decision is made within 24-72 hours of the provider request. If it is approved, you will be able to fill the prescription or a similar drug that is on the drug formulary. If it is denied, you can appeal the denial and ask us to change our decision.

If a drug you take is not covered or it has special restrictions, please ask your provider to submit a request along with your medical records. They can do this online using InTouch at: CommunitySolutions.PacificSource.com/providers

Transition Supplies

If you are new to our CCO plan and a medication you currently take requires prior authorization, we may provide you a transition supply. All network and benefit restrictions still apply. The transition supply is to give your provider time to submit a request for the drug to be covered and ease your transition to a new health plan. If you receive a transition supply, a letter will be mailed to you and your provider. Your provider will need to seek prior authorization for continued coverage of your medication.

Opioid Drugs

The Oregon Health Authority requires initial prescriptions for opioids (a type of drug that treats pain) to be limited to a 7 day supply. This is to help reduce wasted pain medication, decrease costs, and address the risk of opioid misuse in our community.

Billing Information

OHP Members Don't Pay Bills for Covered Services

PacificSource Community Solutions pays for all covered services on the Prioritized List of Health Services. These must be medically appropriate.

Your medical provider can send you a bill only if everything below is true:

- The medical service is something that we do not cover.
- Before you received the service, you signed a waiver. This is called an Agreement to Pay form.
- The form showed the estimated cost of the service.
- The form said that OHP does not cover the service.
- The form said you agree to pay the bill yourself.
- The waiver is valid only if the estimated fee does not change and the service is scheduled within 30 days of your signature and date.

These protections usually apply only if the healthcare provider knew or should have known you had OHP. Also, they only apply to providers who participate in the OHP program (most providers do).

Your provider will not be paid if they don't bill us correctly. That doesn't mean you have to pay. If you already received the service and we do not pay your medical provider, your provider can't bill you. You may receive a notice saying that the service will not be paid. That notice does not mean you have to pay. Also, you should not have to help your provider's office correct billing problems if they occur. If you are asked by your provider to help them get paid, contact PacificSource Customer Service or OHP Client Services.

If you are also enrolled in Medicare, you are not responsible for payment or cost sharing. You are not allowed to be billed for things like missed appointments.

If you are told that the service isn't covered by OHP, you still have the right to challenge that decision by filing an appeal and/or asking for a hearing.

Balance or Surprise Billing:

Providers cannot bill you for separate charges when you get covered services.

Sometimes we may not cover the entire cost of the service and the out of network provider may try to bill you the difference from the amount we paid and the full cost. This is known as "balance billing" or a "surprise bill". This is not allowed. If you get a balance bill, please contact Customer Service.

If You Get a Bill

Even though you don't have to pay, DO NOT IGNORE MEDICAL BILLS. Give us a call right away. Many providers send unpaid bills to collection agencies and even go to court to be paid. It is much harder to fix the problem once that happens. As soon as you get a bill for a service that you received while you were on OHP, you should:

- Call the provider. Tell them that you were on PacificSource Community Solutions and ask them if they have billed us.
- Call our Customer Service department at 503-210-2515, toll-free at 800-431-4135, or

TTY at 711 right away. Say that a provider is billing you for an OHP service. We will help you get the bill cleared up. Do not wait until you get more bills.

- If you receive court papers, call us right away. You may also call an attorney or the Public Benefits Hotline at 800-520-5292 for legal advice and help. There are consumer laws that can help you when you are wrongfully billed while on PacificSource Community Solutions.
- If it turns out that you are responsible for the bill, you can appeal. Send your provider and us a letter saying that you disagree with the bill. Keep a copy of the letter for your records.
- Follow up to make sure we have figured out who is responsible for the bill.

Paying for Medical Services on OHP

You may have to pay for services that are covered by OHP if you see a provider that does not take OHP or is not part of our provider network.

Before you get medical care or go to a pharmacy, make sure that they are in our network. You can find out by looking them up in the Provider Directory by searching online at CommunitySolutions.PacificSource.com/Tools/ProviderDirectory.

You will have to pay for services if:

- You weren't eligible for OHP when you received the service.
- The services are not covered by OHP and you signed an Agreement to Pay form for that specific service before you receive it.

Third Party Liability

Please let us know if you are injured in an automobile, at work, or if someone else is responsible to pay for your injury. We need to make sure the correct insurance is billed. Full use must be made of other possible resources to pay for any injuries. We will make payment on claims only when other means are not available for your medical needs.

For more information or to request a copy of our policies and/or procedures regarding Third Party Liability and Recovery claims, please call Customer Service and request a copy of our guidebook.

Members with Both Medicaid and Medicare

The following information is for any member of your household who has both Medicare and Medicaid (OHP) coverage. They are called "dual eligibles" or duals.

Medicare is health insurance that you pay for when you are working. It is run by the Federal Centers for Medicare and Medicaid Services (CMS). When you become eligible for Medicare, OHP will stop paying for your prescription drugs. Instead, the Medicare Prescription Drug program will pay for your drugs. This drug benefit will be Part D of your Medicare coverage as soon as you are enrolled with Medicare. Medicare may require copays for Part D drug coverage. Some duals have their copays covered by Medicaid. Dual members may be responsible for charges, such as deductibles and coinsurance, if you see an out-of-network provider for a nonemergency.

If you are new to Medicare, we will help make sure you have what you need during this transition and help you with your care coordination. If you have questions, please call our Customer Service team.

For more information on how and when you can enroll in a Medicare plan, or to discuss eligibility changes, please contact our Customer Service team. You can also contact Medicare directly at 1-800-Medicare.

If You Are New to Our Plan

If you are new to our plan, we will provide services and care coordination during your transition period (the first month of enrollment).

This is even if you have not been able to meet with a PCP, PCD, or other provider who prescribes for you. Please see section "Care While You Change Plans" on page 31 for more information on these services. You can call our Customer Service department toll-free at 800-431-4135, Monday through Friday from 8:00 a.m. to 5:00 p.m. to help with your questions.

Other Things You Should Know

Disenrollment

If you lose OHP coverage, please let us try to help you. Call our Customer Service at:

- 503-210-2515 Local
- 800-431-4135 Toll-free
- 711 TTY

The following members may change CCOs or disenroll to Fee-for-Service at any time (this is member choice).

- The member is an American Indian or Alaskan Native with proof of Indian Heritage who wishes to obtain primary care services from their Indian Health Service facility, tribal health clinic/program, or urban clinic and the Fee-For-Service (FFS) delivery system.

PacificSource may ask OHA to disenroll you however you will not be disenrolled without OHA's review and approval. If OHA approves the disenrollment, you will receive a notice to that effect and you may file a grievance if you are dissatisfied with the process. You may also request a hearing if you disagree with the decision to disenroll.

Your enrollment with the plan could end at any time for the reasons below:

- If you lose your OHP eligibility;
- If you move outside of the plan's service area, call OHP Customer Service as soon as you can at 1-800-699-9075.
- If you do not return the paperwork sent to you to reapply for OHP benefits;
- If you commit illegal acts, such as letting someone else use your ID card, changing a prescription, theft or other criminal acts committed in or on any provider's or contractor's premises.
- If you are disruptive or abusive to staff or property, except when this is due to your special needs or disability.
- If you threaten to cause harm or death to others.
- If you commit an act of physical violence, to the point that your continued enrollment in the CCO seriously impairs our ability to furnish services to either you or other members.
- The member is at risk of experiencing a lack of continuity of care. Continuity of care for the purpose of this rule means the ability to sustain services necessary for a person's treatment. A request for disenrollment based on continuity of care shall be denied if the basis for this request is primarily for the convenience or preference of a member for a provider of a treatment, service, or supply.
  - A request for disenrollment based on continuity of care shall be deemed by the Authority a request for an open card for continuity of care and a temporary CCO exemption.
- The member needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.

We cannot request disenrollment solely for reasons related to, but not limited to:

- An adverse change in your health status;
- Utilization of health services;
- Disruptive or abusive behavior resulting from symptoms of a mental or substance use disorder or from any other disability; or
- Whose protected class, medical condition or history indicates probable need for substantial future medical services.

For more information or for questions about other disenrollment circumstances, temporary enrollment exceptions or enrollment exemptions, call our Customer Service or OHP Client Services at either 1-800-273-0557 or 800-699-9075.

You will receive a written notice of disenrollment rights at least 60 days before the start of each enrollment period.

You or your representative may request to disenroll from our CCO orally or in writing if another CCO is available in your service area. The effective date of the disenrollment will be the following month following OHA approval of the disenrollment. Some reasons you may disenroll from the CCO are:

- If you are new to the Oregon Health Plan, during the first 90 days after you enroll.
- At least once every 12 months after you enroll.
- If you are auto-enrolled or manual-enrolled in error, you may change plans if another plan is available within 30 days of enrollment.
- When you renew your OHP coverage (usually once each year).
- You move out of the service area.
- Services are not provided in the preferred language.
- Services are not provided in culturally appropriate manner.
- You are at risk of experiencing a lack of continuity of care.
- Members who are eligible for both Medicare and Medicaid may change plans or disenroll to Fee-for-Service at any time. You must be enrolled with a CCO for dental and mental healthcare.
- Members who are American Indian /Alaska Native beneficiaries may change plans or disenroll to Fee-for-Service at any time.
- If you need services that are not covered by the plan due to moral or religious objections. We do not restrict services for moral or religious reasons.
- If you need related services performed at the same time; not all services are available within the plan's provider network; and your provider determines that receiving services separately would be an unneeded risk.
- If you use MLTSS (Managed Long Term Services and Supports) and your provider's network status would cause disruption in your home or job.
- For other reasons including but not limited to, poor quality of care, lack of access to covered services, an insufficient provider network, or lack of access to in-network providers experienced in dealing with your healthcare needs.
- When the State imposes an intermediate sanction.
- Members can choose to have fee-for-service OHP if they have important OHP-approved medical reason. Examples of sufficient cause include, but are not limited to: (a) moving out of the service area; (b) services are not provided in your preferred language; (c) services are not provided in a culturally appropriate manner; (d) your continued enrollment would be detrimental to your health; or (e) for continuity of care. To do this, please first call Customer Service for help. If we can't help, call OHP Client Services for help at 1-800-273-0557.
- Members may request to change their MCE enrollment after they have been enrolled with a plan for at least six months.

If approved, the change would occur at the end of the month.

- Whenever the Member's eligibility is re-determined by OHA.

If another CCO is available in your area, you have the right to ask to change CCOs. PacificSource Community Solutions does not process these requests. Please talk with your case worker or call OHP Client Services Unit at 800-273-0557. OHP Client Services will help you find out if a change is possible.

How to Change CCOs

If you need to change CCO's, call OHP Client Services at 1-800-273-0557 or 800-699-9075.

Culturally-Sensitive Health Education

We respect the dignity and the diversity of our members and the communities where they live.

We want to make sure our services address the needs of people of all cultures, languages, races, ethnic backgrounds, abilities, religions, genders, sexual orientations, and other special needs of our members. We want everyone to feel welcome and well-served in our plan.

Your provider or clinic can make adjustments for you based on cultural values, language, religion, gender, or other concerns you may have.

If you have any questions, call PacificSource Customer Service.

Advance Directives

If you are an adult, you have the right to know about any medical treatment your provider recommends, and to refuse it if you choose. However, a serious illness or injury could mean you are unable to make decisions or tell someone what you want.

Oregon has a law that allows you to say ahead of time, in writing, how you want to be treated if you are seriously ill or injured and unable to make these decisions for yourself. This is done through a legal form called an advance directive.

The advance directive lets you name a person to make healthcare decisions for you if you are not able to do so. This person is called your healthcare representative. They must agree to represent you by signing the form. Your healthcare representative does not need to be a lawyer or healthcare professional. It should be someone with whom you have discussed your wishes in detail.

The advance directive also lets you give instructions in advance for health providers to follow if you become unable to say what you want (for example, if you are in a coma). It lets you tell your provider to either continue or stop life-sustaining help if you are near death. It also tells your provider if you do not want to have your life prolonged if you have an injury or disease that two doctors agree you will not recover from. You will get care for pain and comfort no matter what choices you make.

If you are able, you have the right to decide your own healthcare, even if you have completed an advance directive. Completing this form is your choice. The plan will not interfere with the instructions provided in your advance directive. If you choose not to complete the form, it will not affect your health plan coverage or your ability to access services.

We are required to update this handbook within 90 days from the date of any change in state law that affects the information in this handbook about advance directives.

You can get a copy of the advance directive at no cost to you by calling our Customer Service department or your local hospital. You can also obtain it from other sources, such as Oregon Health Decisions, by calling 503-692-0894, toll-free 800-422-4805, or online at Oregon.gov/oha/PH/ABOUT/Documents/Advance-Directive.pdf

The advance directive is only valid if you voluntarily sign it when you are of sound mind. Unless you limit the duration, it does not have an expiration date. However, you can cancel it at any time.

Your provider or our plan must provide you with a copy of your advance directive upon request. If you do not receive a written copy, you can file a written complaint with the OHA. Call 800-273-0557 to file a complaint.

For questions or more information, contact Oregon Health Decisions at 503-692-0894, Toll-free 800-422-4805 or TTY 711.

If you think PacificSource did not follow advance-directive requirements (meaning what a plan is to inform members about in the context of advance directives), you can file a complaint with OHA. To file a complaint call 971-673-0540 or TTY 971-673-0372. You can also send your complaint to:

Healthcare Regulation and Quality Improvement
800 N.E. Oregon St., #305
Portland, OR 97232
Email: Mailbox.HCLC@state.or.us

You can find complaint forms and additional information at CommunitySolutions.PacificSource.com/Member/DocumentsandForms.

Declaration for Mental Health Treatment

In a crisis or emergency, a person may be unable to make decisions about their mental health treatment. There is a form to say ahead of time what services the person does and does not want. This form is called a declaration for mental health treatment.

The declaration lets the person give the name of an adult who will make decisions for them. It lets the person say what hospital or other facility they prefer. It lets the person say what medications are okay to use. It also lets the person say what they do not want. The declaration is only valid in Oregon since other states have different rules.

Your provider can tell you about the declaration. They can give you a copy and even help you to fill it out. You can also get a copy of the declaration at no cost to you by calling our Customer Service department toll-free at 800-431-4135 or the OHA Addictions and Mental Health Division at 503-945-5763.

Your provider or PacificSource Community Solutions must provide you with a copy of your declaration if you ask for it. If you are not given a written copy, you can file a complaint with the OHA (Oregon Health Authority) Ombudsperson by calling toll-free 877-642-0450. You may also find a complaint form at Apps.state.or.us/Forms/Served/he3001.pdf

For more information on the declaration for mental health treatment, go to the State of Oregon's website at Aix-xweb1p.state.or.us/es_xweb/DHSforms/Served/le9550.pdf

If your provider does not follow your wishes as stated in your declaration for mental health treatment, you can call 971-673-0540 or TTY 971-673-0372 or send a complaint to:

Healthcare Regulation and Quality Improvement
800 N.E. Oregon St., #305
Portland, OR 97232
Email: Mailbox.HCLC@state.or.us

You can find complaint forms and additional information at HealthOregon.org/hcrqi.

We are Committed to Doing the Right Thing

As a community health plan, we value doing the right thing. We have a Fraud, Waste, and Abuse (FWA) Plan that we follow to ensure we comply with State and Federal laws, and regulations. Please help us stop healthcare fraud by reporting suspicious activities to Customer Service.

For more details, including how to recognize fraud, how to report fraud abuse, and ways you can help prevent healthcare fraud, please contact Customer Service, or visit our website at CommunitySolutions.PacificSource.com/about/compliance.

Complaints and Appeals

Complaints (Grievances)

PacificSource and our providers want to give you the best care possible. If you have a complaint about any part of your care, you can call, write or visit PacificSource staff. Call 541-382-5920 or 800-431-4135. TTY users can call 711.

Send written complaints to:

PacificSource Community Solutions
Attn: Appeals and Grievances
PO Box 5729
Bend, Oregon 97708

Or, fax them to: 541-322-6424.

Our staff will work to address each of your concerns and respond to them within five days. If we need more time to resolve the complaint, a letter will be sent to you in your preferred language telling you that more time is needed and the reason why.

We will send out a final response to you within 30 calendar days from the date we got your complaint.

If you need help completing forms or need more information about how to proceed, give us a call and we will help you.

You can also get help when you submit your complaint. You can have a representative, a representative of the deceased member's estate, a qualified community health worker, a qualified peer specialist, a personal health navigator, or your provider help you with written consent.

You need to give us permission to look into and help you resolve the issue. Please note that we will not tell anyone anything about your complaint unless you ask us to. You may file a complaint directly with the Oregon Health Authority (OHA) Ombudsperson at any time. If you are unhappy with how we handled your grievance, you can share your concerns with the Oregon Health Authority's Client Services unit at 1-800-273-0557 or an Oregon Health Authority Ombudsperson at 1-503-947-2346 or toll-free at 1-877-642-0450. The TTY number is 711. Their fax number is 1-503-947-2341.

Appeals

The plan also has an appeals process if you disagree with a decision to deny coverage or payment of services requested. The deadline to file an appeal is 60 calendar days from the date in the denial letter you receive from us. The denial letter is called a "Notice of Adverse Benefit Determination."

To process your appeal, you can tell us either verbally or in writing. Your Notice of Adverse Benefit Determination letter will include an appeal form.

Ways to submit an appeal:

- You can verbally submit an appeal by calling Customer Service at (800) 413-4135 or TTY (800) 735-2900.
- You or your representative or the representative of the deceased member's estate can ask for an appeal.
- Your provider or another person can file it for you with your written permission.
- You may also write a letter to us with your concerns.

You also have the right to have a qualified

community health worker, qualified peer specialist, or a personal health navigator help you in sending us an appeal. For more information, please call Customer Service. If you need another form or want help, call Customer Service at 541-382-5920, toll-free at 800-431-4135, or TTY at 711. We will send you another form, help you in filling it out, or guide you through the appeals process.

The written appeal should be sent to:
PacificSource Community Solutions
Attn: Appeals and Grievances
PO Box 5729
Bend, Oregon 97708
You can also fax it to 541-322-6424.

Before you send in the appeal form:

It is helpful to include any documents you feel will help us in making a decision. You have 60 calendar days to submit your request.
You do not have to wait until you have all your information to send us the appeal. You can give us more information during the appeals process. You can also tell us who to call and we can get it for you.

We will send you a letter within five calendar days of getting your appeal. This is to let you know we are looking into your issue. All issues are reviewed carefully. It may take up to 16 calendar days to give you a written decision. You need to give us permission to look into and help you resolve the issue. Please note that all information gathered during this process is kept private.

For standard appeals, we can extend the review time frame up to 14 calendar days. We would do this if either you or the plan need more time to get information that would benefit your appeal. If we decide to extend your appeal, we will call you as soon as possible to let you know. A letter explaining why we are delaying the time frame will be sent to you within 2 days. If you don't agree with this, you have the right to file a complaint.

Expedited Appeals for Urgent Medical Problems

If you believe your medical problem cannot wait for a regular appeal, you can ask for an expedited (fast) appeal. You should include a statement from your provider that explains why it is urgent. Or, you can ask them to call us.

If your provider supports your request for a fast appeal, we will automatically process it in 3 days (72 hours). Your provider needs to call us or contact us in writing to tell us of this need.

For fast appeals, we can extend the review time frame up to 14 calendar days. We would do this if either you or the plan need more time to get information that would benefit your appeal.

If we decide to extend your appeal, we will call you as soon as possible to let you know. A letter telling you why we are delaying the time frame will be sent to you within 2 days. If you don't agree with this, you have the right to file a complaint.

Your provider can support your appeal by sending us your medical records when we ask for them. If your provider is in the PacificSource network, he or she can also file an appeal to have services covered for you. Your provider should include your medical records with their appeal.
Having a provider file an appeal on your behalf does not mean that your 60 calendar day time frame to file an appeal will be extended.

Having a provider file an appeal on your behalf does not mean that your 60 calendar day time frame to file an appeal will be extended.

Oregon Health Authority Administrative Hearings

If you appeal a decision and we deny your appeal, you or your representative also have the option to ask for an administrative hearing through the State. If we did not make a decision in the required amount of time, you or your representative have the right to ask for a hearing through the state.

If you appeal a decision and we deny your appeal, you or your representative also have the option to ask for an administrative hearing through the State. If we did not make a decision in the required amount of time, you or your representative have the right to ask for a hearing through the state.

Your Notice of Appeal Resolution letter will have a Hearing Request form that you can send in to the State to ask for a hearing. You can also ask us to send you a Hearing Request form, or call OHP Client Services toll-free at 800-273-0557. TTY users call 711 to ask for a form.

You must make your request within 120 days from the date of the decision notice.

If you appeal to OHA, they will schedule a hearing within 45 days of your request.

If you believe your medical problem can't wait the regular time for a hearing, you can ask for a fast (expedited) hearing. OHA will review your case and decide if it qualifies for the faster hearing. They will tell you if your case can be expedited within 2 business days.

At the hearing, you can explain why you do not agree with the plan's decision, and why they should cover the services you requested.

Hearings are held before a neutral person called an Administrative Law Judge. They are usually held over the phone, but you can request one in person. Representatives from OHA Health Services Division (formerly the Division of Medical Assistance Programs (DMAP)) and PacificSource Community Solutions will be at the hearing. If you need an interpreter, your Hearings Representative will arrange for one.

At the hearing, you can tell the judge why you do not agree with the decision and why you think OHP should cover the service(s). You do not need a lawyer, but you can have one. You can also ask someone else — such as your doctor, friend, or relative — to be with you. You can fill out the section in the hearing request form to name a representative who will speak for you at the hearing. The representative can be anyone you choose.

Make sure that the representative you name is willing and able to speak for you at the hearing. You can also have witnesses speak (for example: your child, friend, caregiver, or provider). Neither OHA nor PacificSource Community Solutions will pay for the cost of a lawyer. However, you may try the following options:

- Call the Public Benefits Hotline (a program of Legal Aid Services of Oregon and the Oregon Law Center) toll-free at 800-520-5292, TTY 711 for advice and possible representation. Legal Aid information can also be found at OregonLawHelp.org.
- You also may be able to get free or reduced cost legal services through the Oregon State Bar Association at 800-452-8260.

If your problem is resolved after you have requested an administrative hearing, please tell the Hearings Representative handling your case.

Continuation of Benefits

The plan may continue to cover the service requested while waiting for an appeal or hearing decision. In order to have this, you must ask to appeal within 10 days from the "Date of Notice" on your Benefit Denial letter. If your appeal is denied you must ask OHA for a hearing within 10 days from the "Date of Notice" on your Notice of Appeal Resolution. You can only ask for a hearing, after your appeal is complete.

To continue services, the services must have already started. The plan must have stopped or reduced the service. (For example, PacificSource Community Solutions approved 20 physical therapy visits. After you had been to 10 visits, the plan decided not to cover the other 10.)
The services must have been ordered by an authorized provider. The original period covered by the original prior authorization must not have expired.
If we continue to cover the services, we will

cover them while waiting for the decision, until one of the following occurs:
If we continue to cover the services, we will cover them while waiting for the decision, until one of the following occurs:

- You cancel the appeal or hearing;
- The appeal decision or final order on the hearing is not to your benefit; or
- The effective dates for the previously approved service have expired, or you have used up the number of approved services.

If the decision on the appeal or hearing is not to your benefit, the plan will ask for the money back on any services that were covered after you received the denial letter.

Appeal Rights Available to Providers

If services have been denied to you, your providers are allowed to file an appeal on your behalf. They need permission to appeal on your behalf as a representative. There is a form they can use located on our website, at: CommunitySolutions.PacificSource.com

Your provider should include your medical records with their appeal, and a reason why the plan should cover the service.

Medicare Appeals

If you also have Medicare benefits, you may have additional appeal rights. Please call our Customer Service department for more information at 541- 382-5920, toll-free at 800-431-4135, or TTY at 711.

How to Get Information About Complaints (Grievances) and Appeals

If you need any documents or forms related to a grievance or appeal, please contact Customer Service toll-free at 800-431-4135, or TTY at 711. We can also provide copies of written notice of denials showing why a service is not covered.

Member Rights and Responsibilities

Member Rights

- To be treated with dignity and respect.
- To be treated by providers the same as other patients.
- Learn about CCO's and the health care system.
- To get covered behavioral health, substance use treatment, family planning, or related services without a referral. If you want to access these services on your own, this is called a self-referral.
- To have a friend or helper come to your appointments to help support you.
- To be involved in making a health plan for your care.
- To get information on all of your covered and noncovered treatment options to help you make a decision.
- To get information about your condition, what is not covered so you can make good decisions about your treatment. You can get this information in your language and in a format that works for you.
- Accept or refuse treatments and be told what might happen based on your decision. A court-ordered service cannot be refused.
- To be told what happens if you agree or don't agree with services.
- To get written materials describing rights, responsibilities, and benefits available.
- How to get services, and what to do in an emergency.
- To get meaningful medically appropriate services for physical, behavioral, and oral health in all avenues of care.
- To find out what care you need and how you can get treatment.
- To get necessary and reasonable services to diagnose your condition.
- To get integrated person-centered care and services that provide choice, independence, and dignity.
- To have a stable relationship with a care team that is responsible for your care management.
- To get help navigating your healthcare. This includes support and services for all of your healthcare needs. This could include:
  - Certified or qualified health care interpreters
  - Certified traditional health care workers
  - Community health workers
  - Peer wellness specialists
  - Peer support specialists
  - Doulas
  - Personal health navigators
- Get care coordination, community based care, and help with care transitions in a way that works with your language and culture to reduce the need for hospital or nursing facility visits.
- Get covered preventative services;
- Get urgent and emergency services 24 hours a day, seven days a week without prior authorization;
- Get certified or qualified health care interpreter services, including sign language interpretation.

- To have access to the OHP ombudsperson.
- To get covered services under OHP in a way that meets all requirements by law.
- To see a specialist with a prior authorization if you need to for covered services.
- To have a record kept with documents, a list of conditions, care you get and referrals you are given.
- To see and get a copy of your health records unless restricted by law or OARs. (Oregon Administrative Rules).
- To have your records corrected.
- To send a copy of your record to another provider.
- To make a statement of wishes for services (advance directive) and get a power of attorney for healthcare.
- To find out in writing you are denied benefits or if they change, unless it is not required by federal or state Oregon Administrative Rules.
- To get materials in a timely manner per OHA and CMS guidelines. To get in writing your right to request and obtain information at least once a year.
- To speak to staff members that are fully informed of all company policies.
- To know how to make a complaint, grievance or appeal and get a response.
- To ask for an administrative hearing with the DHS or OHA.
- To be told if an appointment is cancelled in a timely manner.
- To get notice of DHS/OHA privacy practices. A paper called "Notice of Privacy Practices" explains OHP members' rights to keep their personal information private and how their personal information is used.
- To choose or change your provider.
- To have the plan's written materials explained so you can understand it. This includes alternate formats such as video or audio.
- To make complaints and not be treated bad by the plan or provider.
- To get care when you need it, 24 hours a day, seven days a week.
- To be able to limit who can see your health records.
- To be free from any form of restraint or seclusion (isolation) that is not medically necessary. Staff may not do this to bully or punish you.
- To help to make decisions about your healthcare about refusing services:
  - Without being held down,
  - Being kept away from other people,
  - Being forced to do something you don't want to do,
  - To exercise all rights if the member is a child, as defined by OARs.
- To get culturally and linguistically appropriate services and support as close to where you live or seek services.
- To get timely access to care and services.
- To have adequate access to covered services and providers.
- To access to integrated treatment or care plans for members:
  - With special healthcare needs;
  - Receiving long-term services and support;
  - Who are transitioning from a hospital or skilled nursing facility care;
  - Who are transitioning from institutional or in-patient behavioral healthcare;
  - Who are receiving home and community-based services for behavioral health conditions;
  - and members with both Medicare and Medicaid.

- To get a second opinion from a provider within your plan's network. We can help if you want a second opinion outside of your plan's network. Second opinions are available at no cost to you.
- Rights of minors (under age 18) - see page 67.
- To not have services restricted for moral or religious reasons.

Residential Services Rights

In addition to the rights listed above, every individual receiving residential services has the following rights:

- To a safe, secure, and clean setting to live.
- To a caring service environment that has;
- Reasonable protection from harm;
- Reasonable privacy;
- Access to fresh air and the outdoors every day;
- To keep and use your own clothing and things you own;
- To have storage space that is just for you to keep your things safe;
- To express sexual orientation;
- Gender identity and gender presentation;
- To get to and be part of social, religious, and community activities;
- To private and uncensored communications by mail, telephone, and visits, so long as they follow these restrictions:
  - This right may be taken away only if the provider documents in the individual's record that there is a court order that says something else, or
  - This right may be taken away if serious physical harm will result to the individual or others. (The nature of the harm must be specified in reasonable detail. Any restriction of the right to communicate must be no broader than necessary to prevent this harm) and
  - The individual and his or her guardian, if applicable, must be given specific written notice of each restriction of the individual's right to private and uncensored communication.
- The provider must make sure that letters are easy to get and send.
- That telephones are reasonably able to use and allow for you to talk in private. (Reasonable times for the use of telephones and visits may be established in writing by the provider)
- There is space for you to use to have visits.
- To have access to and get available applicable educational services in the most integrated setting in the community.
- To talk privately with public or private rights protection programs or rights advocates, clergy, and legal or medical professionals.
- To have regular time inside and outside for recreation.
- To not be made to do work.
- To have enough food and shelter.
- To a reasonable accommodation if you have a disability and the housing and services are not sufficiently accessible

Rights of Members Under the Age of 18

There are times when people under age 18 (minors) may want or need to get healthcare services on their own. To learn more, read "Minor Rights: Access and Consent to Healthcare." This booklet tells you what services minors can get on their own and how minors' healthcare information may be shared.

You can read this booklet online at OHP.Oregon.gov. Click on "Minor rights and access to care."

PacificSource Community Solutions Provider Payments and Incentives

You have the right to ask if the plan gives our providers special payments. Special payments are payments to cut down the use of referrals and or other services that you might need. To get this information, call our Customer Service Department. 503-210-2515, or toll-free 800-431-4135. TTY users should call 711. We are open

- October 1 - January 31
  7 days a week
  8:00 a.m. to 8:00 p.m.
- February 1 - September 30
  Monday through Friday
  8:00 a.m. to 5:00 p.m.

Ask for information about our provider payment arrangements.

PacificSource Community Solutions Business Structure and Operations

PacificSource Community Solutions, an Oregon nonprofit corporation, was started in 1995 and has office locations in each of our coordinated care organization "CCO" regions. That means we have offices and work in each area that we have coverage in. We do this through a contract we have with Oregon Health Authority (OHA) to serve the people on the Oregon Health Plan (OHP).

We are run by a Board of Directors. The Board looks at the way the company is run. This is also called operations. Our main management team is located in our Bend office. This team handles our day-to-day work.

We were started with the hope of working with Oregon Health Authority in supporting people with the Oregon Health Plan so that our members have:

- a quality product
- excellent and local Customer Service
- help in getting healthcare

We work hard so this idea can happen. We always look for ways to help our services be the best they can and give value to our members.

We have contracts with many doctors, which means these doctors agree to set payments for services our members get at one price. Some of our contracts have risk-sharing. This means we hold a portion of the payment we owe to the doctor.

In some cases, we pay the doctor a set amount per member per month for some of the services they get. At the end of the year, PacificSource Community Solutions and the doctor determine whether payments are owed to the doctor. This payment is owed if we have the set amount of savings in the contract.

Our contracts have stop-loss. Stop loss insurance is a plan to protect against the danger that any one claim will be over a specific dollar amount or that an entire plan's losses will be higher than a specific amount. Doctors with contracts have limited financial risk. At no time do payments or holding of payments limit or cut needed services our members need. Our contracts and payments to doctors do not change the use of referrals. We do not let payments or the holding of payments affect member's care.

You have the right to ask about the structure of PacificSource Community Solutions and how it operates. To get this information, call our Customer Service Department, 503-210-2515, or toll-free 800-431-4135. TTY users should call 711. We are open:

- October 1 – January 31
  7 days a week
  8:00 a.m. to 8:00 p.m.
- February 1 – September 30
  Monday through Friday
  8:00 a.m. to 5:00 p.m.

Member Responsibilities

As an OHP member, you have the following responsibilities:

- To choose, or help with assignment to, a managed care plan (such as PacificSource Community Solutions).
- To choose a primary care provider (PCP).
- To pick or help us pick a behavioral health provider for you.
- To take your PacificSource Community Solutions Identification (ID) card with you whenever you need care.
- To treat PacificSource Community Solutions staff and health provider staff with respect.
- To be on time for appointments or call before to cancel if you are not able to come in or if you are going to be late.
- To tell your provider about your behavioral health problems.
- To think about care before you get it.
- To get behavioral health services from in-network providers. You may go to an out-of-network provider only in an emergency.
- To use only the behavioral health provider for your behavioral health needs that you picked out.
- To get regular health exams and preventive services from your providers.
- To have yearly check-ups, wellness visits, and other services to keep you from getting sick and keep you healthy.
- To go to your PCP or clinic to find out what is wrong and get care unless it is an emergency.
- To get a prior authorization before you see a specialist for a noncovered condition.
- To use urgent and emergency services only when needed.
- To give accurate information for your medical records.
- To help your providers obtain your medical records from other providers, which may include signing a release of information form.
- To ask questions about conditions, treatments, and other issues about your care that you don't understand.
- To use information to make informed decisions before receiving treatment.
- To be honest with your providers to get the best service possible.
- To help create treatment plans with your providers.
- To follow prescribed treatment plans to which you have agreed.
- To tell the provider that you have OHP coverage before receiving services and to show your plan ID card upon request.
- To tell your caseworker if you change your address or phone number.
- To tell your caseworker if you become pregnant, let him or her know when you are no longer pregnant or when your baby is born.
- To tell your caseworker if any family members move in or out of your house.
- To tell your caseworker and providers if you have any other insurance available.
- To pay for services that are not covered by your plan.
- To help the plan in pursuing any third party resources available (such as Workers' Compensation or auto insurance).
- To pay the plan the amount of benefits it paid for an injury from any payment received for that injury.
- To tell the plan of any issues, complaints, or grievances about your care.
- To sign an authorization for release of healthcare information so that OHP and the plan can get information needed to respond to an administrative hearing request.

Fraud, Waste & Abuse

PacificSource Community Solutions is committed to preventing fraud, waste, and abuse. We comply with all applicable laws, including the Oregon False Claims Act and the federal False Claims Act.

We're a community health plan, and we want to make sure that healthcare dollars are spent helping our members be healthy and well. We need your help to do that. If you think fraud, waste, or abuse has happened report it as soon as you can. You can report it anonymously. Whistleblower laws protect people who report fraud, waste, and abuse. You will not lose your coverage if you make a report. It is illegal to harass, threaten, or discriminate against someone who reports fraud, waste, or abuse.

Examples of Fraud, Waste and Abuse by a Provider:

- Your provider billing for services or medical equipment that you did not receive.
- Your provider charging you for services that are covered by your health plan.
- Your provider giving you a service you don't need based on your health condition.

Examples of Fraud, Waste and Abuse by a Member:

- Going to multiple doctors for prescriptions for a medication already prescribed to you.
- Letting another person use your healthcare benefits.

Reporting Fraud, Waste, and Abuse

Report fraud, waste, and abuse to PacificSource Community Solutions. To report fraud, waste, and abuse you can:

- Call our Customer Service team at 800-431-4135, or
- Email them at CommunitySolutionsCS@PacificSource.com.

We will send each report of suspected fraud, waste, and abuse committed by a provider or a member to the appropriate state agency listed below.

For Reports of Fraud, Waste, and Abuse by a Provider:

Medicaid Fraud Control Unit (MFCU)
Oregon Department of Justice
100 SW Market Street
Portland, OR 97201
Phone: 971-673-1880
Fax: 971-673-1890

Or

OHA Office of Program Integrity (OPI)
3406 Cherry Ave. NE
Salem, OR 97303-4924
Fax: 503-378-2577
Hotline: 1-888-FRAUD01 (888-372-8301)
http://www.oregon.gov/oha/FOD/PIAU/Pages/Report-Fraud.aspx

For Reports of Fraud, Waste, and Abuse by a Member:

DHS Fraud Investigation Unit
PO Box 14150
Salem, OR 97309
Hotline: 1-888-FRAUD01 (888-372-8301)
Fax: 503-373-1525 Attn: Hotline
http://www.oregon.gov/oha/FOD/PIAU/Pages/Report-Fraud.aspx

Your Health Records Are Private

The Notice of Privacy Practices will tell you how PacificSource Community Solutions may use or disclose (share) health information about you. This information is called protected health information (PHI). Not all situations will be described. We are required to protect health information by federal and state law. We are required to follow the terms of the notice currently in effect. When this notice says "we," it means PacificSource Community Solutions. You have the right to ask Customer Service for a copy of this notice at any time.

You may view this notice on line at: CommunitySolutions.PacificSource.com

We May Use and Disclose Health Information Without Your Approval:

- For Treatment. We may use or disclose PHI with healthcare providers who are involved in your healthcare. For example, information may be shared to create and carry out a plan for your treatment.
- For Healthcare Operations. We may use or disclose PHI in order to manage programs and activities. For example, we may use PHI to review the quality of services you receive.

We May Use or Disclose Health Information Without Your Approval for the Following Purposes Under Limited Circumstances:

- Appointments and Other Health Information. We may send you reminders for medical care or checkups. We may send you information about health services that may be of interest to you.
- For Health Oversight. We may use or disclose PHI for government healthcare oversight activities. Examples are audits, investigations, inspections, and licenses.
- For Law Enforcement and As Required by Law. We will disclose PHI for law enforcement and other purposes as required or allowed by federal or state law.
- For Disputes and Lawsuits. We will disclose PHI in response to a court order. We will disclose PHI in response to an administrative order. If you are involved in a lawsuit or dispute, we may share your information in response to legal requirements.
- Workers' Compensation. We may disclose PHI as allowed by law to workers' compensation or like programs.
- To Avoid Harm. We may disclose PHI in order to avoid a serious threat to your health and safety or to the health and safety of a person or the public.
- For Research. We use PHI for studies and to develop reports. These reports do not identify specific people.
- Disclosures to Family, Friends, and Others. We may disclose PHI to your family or other persons who are involved in your healthcare. You have the right to object to and limit the sharing of this information.
- Other Uses and Disclosures Require Your Written Permission. For other purposes, we will ask for your written permission before using or disclosing PHI. You may cancel this permission at any time in writing. We cannot take back any uses or disclosures already made with your permission.
- Other Laws Protect PHI. Many programs have other laws for the use and disclosure

of health information about you. For example, usually you must give your written permission for us to use and disclose your mental health and chemical dependency treatment records.

Your PHI Privacy Rights

- Right to See and Get Copies of Your Records. In most cases, you have the right to look at or get copies of your health records. You may be charged a fee for the cost of copying your records. You must make the request in writing. Please send it to PacificSource Community Solutions, PO Box 5729, Bend, OR 97708. We will answer your request within 30 days. If for any reason this information is not in our office, we will answer within 60 days.
- Right to Request a Correction or Update of Your Records. You may ask to change or add missing information to health records we created about you, if you think there is a mistake. You must make the request in writing and provide a reason for your request. We may deny your request in certain circumstances.
- Right to Get a List of Disclosures. You have the right to ask us for a list of your PHI disclosures made after April 14, 2003. You have the right to receive an accounting of certain disclosures of your information made by us during the six years prior to your request. You must make the request in writing. This list will not include the times that information was disclosed for treatment, payment, or healthcare operations. The list will not include information provided directly to you or your family, or information that was sent with your authorization. If you request a list more than once during a 12-month period, you may be charged a fee.
- Right to Request Limits on Uses or Disclosures of PHI. You have the right to ask that we limit how your health information is used or disclosed. You must make the request in writing and tell us what information you want to limit and to whom you want the limits to apply. We are not required to agree to the restriction. You can request in writing or verbally that the restrictions be ended.
- Right to Revoke Permission. If you are asked to sign an authorization to use or disclose PHI, you can cancel that authorization at any time. You must make the request in writing. This will not affect information that has already been shared.
- Right to Choose How We Communicate With You. You have the right to ask that we share PHI with you in a certain way or in a certain place. For example, you may ask us to send information to your work address instead of your home address. You must make this request in writing. You do not have to explain the reason for your request.
- Right to File a Complaint. You have the right to file a complaint if you do not agree with how we have used or disclosed health information about you. Your benefits will not be affected by any complaints you make. We cannot hold it against you if you file a complaint. We cannot hold it against you if you cooperate in an investigation. We cannot hold it against you if you refuse to agree to something that you believe to be unlawful.
- Right to Get a Copy of this Notice. You have the right to ask for a copy of this notice at any time.

Using Your Rights and Complaints

If you think your privacy has been shared when it should not have been, you may send a written complaint to our Privacy Contact. Privacy rules are overseen by the Compliance Officer, who also acts as the Privacy Officer.

We will not treat you badly because of your complaint. Please send your complaint to:

PacificSource Community Solutions:
Attn: Appeals and Grievances
PO Box 5729
Bend, OR 97708

You may also send your complaints to:

Oregon Health Authority Ombudsperson
500 Summer Street NE, E-17
Salem, OR 97310
877-642-0450 Toll-free, 711 TTY
503-947-2341 Fax

U.S. Department of Health and Human Services
200 Independence Ave. SW
Room 509F, HHH Building
Washington, D.C. 20201
866-627-7748 Toll-free
886-788-4989 TTY

If you would like a copy of our confidentiality policy or have any questions, please call Customer Service.

Words To Know

Appeal – When you ask your plan to review a decision it made about a healthcare service. If you do not agree, you can appeal it and ask to have the decision reviewed.

Advance Directive - A written instruction, such as a living will or durable power of attorney for healthcare, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of healthcare when the individual is incapacitated (42 CFR 489.100).

Adverse Benefit Determination – A letter we send to you that tells you why we denied coverage or payment of services that you asked for. The letter also tells you how you can appeal the decision we made.

Care Coordination - An organized coordination of a Member's healthcare services, support activities and resources.

Copay or Copayment – Your health plan pays for services but some plans, like Medicare, charge the member a small fee. That fee is called a copay. OHP does not have copays.

Coordinated care organization (CCO) – OHP has local health plans that help you use your benefits. These plans are called coordinated care organizations or CCOs. CCOs have providers who work together in your community.

Devices for Habilitation and Rehabilitation – Equipment to help you benefit from habilitation and/or rehabilitation therapy services or meet other clinical or functional needs. Examples include walkers, canes, and crutches, glucose monitors and infusion pumps, prosthetics and orthotics, low vision aids, augmentative communication devices, and complex rehabilitation technologies, such as motorized wheelchairs and assistive breathing machines.

Direct Access – No prior authorization or referral is needed.

Durable Medical Equipment (DME) – Things like wheelchairs, walkers, and hospital beds. They are durable because they last a long time. They don't get used up like medical supplies.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) – Services are available for Medicaid eligible children from birth through age 20. EPSDT's goal is to assure that individual children get the healthcare when and where they need when they need it.

Emergency Dental Condition - "Dental Emergency Condition" means a condition based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a Healthcare Professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results. Emergency Dental Condition may include but is not limited to severe tooth pain, unusual swelling, or an avulsed tooth.

Emergency Medical Condition – An illness or injury that needs care right now. This can be bleeding that won't stop, severe pain, or broken bones. It can be something that will cause some part of your body to stop working right. An emergency mental health condition is feeling out of control or feeling like hurting yourself.

Emergency Medical Transportation – Using an ambulance to get to care. Emergency medical technicians (EMT) give you care during the ride or flight. This happens when you call 911.

ER and ED – Emergency Room and Emergency Department. This is the place in a hospital where you can get care right now.

Emergency Room Care – Care you get when you have a serious medical issue and it is not safe to wait. This care happens in an emergency room (ER).

Emergency Services – Care you get during a medical crisis. These services help make you stable when you have a serious condition.

Excluded Services – Things that a health plan doesn't pay for. Services to improve your looks, like cosmetic surgery, and for the things that get better on their own, like colds, are usually excluded.

Grievance – A complaint about a plan, provider, or clinic. The law says CCOs must respond to each complaint.

Habilitation Services and Devices – Services and devices that teach daily living skills. An example is speech therapy for a child who has not started to speak.

Health Insurance – A program that pays for some or all of its members' healthcare costs. A company or government agency makes the rules for when and how much to pay.

Health Risk Screening – Every member will get a survey after they enroll about their overall health. This will be done at least once a year. PacificSource will contact the member by phone or mail to complete this survey. The survey will ask the member about their emotional and physical health, behaviors, living conditions, and family history. We will use this information to connect the member to resources and support that will help the member's overall health.

Home Healthcare – Services you get at home to help you live better. For example, you may get help after surgery, an illness, or injury. Some of these services are help with medicine, meals, and bathing.

Hospice Services – Services to comfort a person who is dying and their family. Hospice can be pain treatment, counseling, and respite care.

Hospital Inpatient and Outpatient Care – Hospital inpatient care is when the patient is admitted to a hospital and stays at least 3 nights. Outpatient care is surgery or treatment you get in a hospital and then leave afterward.

Hospitalization – When someone is checked into a hospital for care.

Intensive Care Coordination – Some members with special healthcare needs (e.g., older adults, disabled individuals, individuals with multiple and chronic conditions, children with behavioral problems, individuals using IV drugs, women with high risk pregnancy, veterans and their families, and those with HIV/AIDS or tuberculosis) will receive additional assistance and resources to help them manage their health.

Medicaid – A national program that helps with healthcare costs for people with low incomes. In Oregon, it is part of the Oregon Health Plan.

Medically Necessary – Services and supplies that your doctor says are needed. They are needed to prevent, diagnose, or treat a condition or its symptoms. It can mean services that a provider accepts as standard treatment.

Medicare – A healthcare program for people 65 or older. It also helps people with disabilities of any age

Network – The group of providers that a CCO has a contract with. They are the doctors, dentists, therapists, and other providers that work together to keep you healthy.

Network Provider – A provider the CCO chooses to have a contract with. If you see network providers, the CCO pays. Some specialists need members to get a referral from their primary care provider (PCP).

Non-Network (Non-Participating) Provider – A provider that does not have a contract with the CCO. They may not accept the CCO payment for their services. You might have to pay if you see a non-network provider.

OHP Agreement to Pay (OHP 3165 or 3166) Waiver - A form that you sign if you agree to pay for a service that OHP does not pay for. It is only good for the exact service and dates listed on the form. You can see the blank waiver form at

https://bit.ly/OHPwaiver. Unsure if you signed a waiver form? You can ask your provider's office.

Participating Provider – A provider the CCO chooses to have a contract with. If you see network providers, the CCO pays. Also called an "in-network provider."

Physician Services – Services that you get from a doctor.

Plan – A company that arranges and pays for healthcare services. Most plans have physical, dental, and mental healthcare.

Premium – The cost of insurance.

Prescription Drug Coverage – Health insurance or plan that helps pay for medications.

Prescription Drugs – Medications that your doctor tells you to take.

Primary Care Provider or Primary Care Physician (PCP) – The medical professional who takes care of your health. This is usually the first person you call when you have health issues or need care. Your PCP can be a doctor (such as a gynecologist, obstetrician, pediatrician), nurse practitioner, physician's assistant, osteopath, or sometimes a naturopath.

Primary Care Dentist – The main dentist who takes care of your teeth and gums.

Prior Authorization (Preapproval or PA) – Permission for a service. This is usually a document that says your plan will pay for a service. Some plans and services require this before you get the care.

Provider – A licensed person or group that offers a healthcare service. For example, a doctor, dentist, or therapist.

Rehabilitation Services – Services to help you get back to full health. These help usually after surgery, injury, or substance abuse.

Self-Referral – Choosing a provider or service without waiting on prior authorization through your insurance or another provider. You can schedule your appointment or service by contacting your provider directly.

Skilled Nursing Care – Help from a nurse with wound care, therapy, or taking your medicine. You can get skilled nursing care in a hospital, nursing home, or in your own home with home healthcare.

Specialist – A provider trained to care for a certain part of the body or type of illness.

Transition of Care – Some members who change OHP plans can still get the same services and see the same providers. That means care will not change when you switch CCO plans or move to/from OHP fee-for-service. This is called transition of care. If you have serious health issues, your new and old plans must work together to make sure you get the care and services you need.

Urgent Care – Care that you need the same day. It could be for serious pain, to keep you from feeling much worse, or to avoid losing function in part of your body.

Customer Service

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Local: 503-210-2515
Toll-free: 800-431-4135
TTY/TDD: 711

Hours:
October 1 – January 31
7 days a week
8:00 a.m. to 8:00 p.m.

February 1 – September 30
Monday through Friday
8:00 a.m. to 5:00 p.m.

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