



PacificSource Coordinated Care Organization (CCO) (Your Oregon Health Plan Coverage) Columbia Gorge

For members who live in Wasco and Hood River counties.

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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 toll-free at (800) 431-4135. Our TTY/TDD number is (800) 735-2900. We are open Monday - Friday, 8:00 a.m. - 5:00 p.m.

If you need another copy of this handbook, you can find it online at www.CommunitySolutions.PacificSource.com or we can mail you a copy. Please call Customer Service if you need a copy mailed to you.

Si necesita servicios de intérprete, llame al (800) 431-4135. Este manual está disponible en español a petición del interesado al (800) 431-4135.

Welcome to PacificSource, Your Oregon Health Plan Health Insurance

Quick Start 1-2-3-4!

- 1.** Get connected with a doctor.
 - Check to see who is listed as the Primary Care Provider (PCP) on your PacificSource Community Solutions 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.
 - 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 with PacificSource Community Solutions.
- 2.** Get connected with a Primary Care Dentist (PCD). Call the Dental Care Organization listed on your 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
 - (800) 735-2900 TTY
 - 8:00 a.m. - 5:00 p.m. Monday - Friday
 - 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, 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) 699-9075.
- 4.** The benefits chart included in this handbook lists the services our plan covers. These services are subject to your eligibility for OHP, pre-approval requirements, and where your condition ranks on the Prioritized List of Health Services. The Prioritized List of Health Services is a list of covered conditions and treatments.
 - Some services need to be approved in advance (pre-approved) by PacificSource Community Solutions. Call Customer Service if you need more information about which services are covered and if they need to be approved in advance (pre-approved). 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.

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Important Telephone Numbers and Contact Information

PacificSource Customer Service

Mailing Address:

PacificSource Community Solutions
PO Box 5729
Bend, OR 97708-5729
www.CommunitySolutions.PacificSource.com

Building Location:

2965 NE Conners Avenue
Bend, OR 97701

Customer Service Department

(800) 431-4135 Toll-free
(800) 735-2900 TTY
(541) 322-6423 Fax
8:00 a.m. - 5:00 p.m., Monday - Friday

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.
- Are in the first month of enrollment (are unable to see your PCP) and need a prescription, supplies, or other necessary items or services.
- 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 four 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
www.AdvantageDentalServices.com

Capitol Dental Care

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

ODS Community Health

Customer Service:
(800) 342-0526 Toll-free
711 TTY
www.ModHealth.com

Important Telephone Numbers and Contact Information

Community Mental Health Programs

Hood River County

Mid-Columbia Center for Living
1610 Woods Court
Hood River, OR 97031

(541) 386-2620
(800) 735-2900 TTY

8:30 a.m. – 5:00 p.m., Monday – Friday
www.mccfl.org

Wasco County

Mid-Columbia Center for Living
419 East 7th Street
The Dalles, OR 97058

(541) 296-5452
(800) 735-2900 TTY

8:00 a.m. – 6:00 p.m., Monday – Friday
www.mccfl.org

Mental Health Regional Crisis Line

(Available after hours)
(866) 877-9147 Toll-free
(800) 735-2900 TTY

Oregon Health Plan Customer Service

(800) 699-9075 Toll-free
711 TTY

www.oregon.gov/oha/healthplan/Pages/contact_us.aspx

Client Services

(800) 273-0557 Toll-free
711 TTY

Call Oregon Health Plan Customer Service to:

- Check the status of an OHP application.
- Tell them your correct address or phone number.
- Report that you have changed your name.
- Add your new baby to the Oregon Health Plan.
- Change your Coordinated Care Organization.

Transportation Services

For more information call The Transportation Network, Monday - Friday, 7:00 a.m. to 5:00 p.m. at:

- (877) 875-4657 Toll-free
- (800) 735-2900 TTY

Benefits Chart

| Covered Benefits | Benefit Details |
|---|--|
| Alternative Care | Services must be approved in advance by PacificSource for treatment of a covered illness or injury. |
| Ambulance Services | We cover ambulance services for one-way transportation during emergencies only. |
| Behavioral and Mental Health Services | <p>You do not need a referral for this service. Please see Behavioral Health Services section for more information.</p> <p>For children's services, see ICTS in the benefits chart. We cover:</p> <ul style="list-style-type: none"> • Case management consultations. • Emergency services. • Evaluations and assessments. • Hospitalization. • Medication management. • Programs to help with daily and community living. • Psychiatric residential and day treatment. • Counseling. |
| Children's Care (age 20 and under) | <p>Eye Care and Eyeglasses</p> <ul style="list-style-type: none"> • There is no limit to coverage of eye exams and new glasses if they are medically necessary. • Your PCP or other healthcare provider decides medical necessity. • OHP will pay for contact lenses for only a few conditions. <p>Newborn Care</p> <ul style="list-style-type: none"> • Your baby has medical coverage until his or her first birthday, even if you are no longer on OHP. <p>Shots</p> <ul style="list-style-type: none"> • Certain shots are covered for children. (Shots for travel are not covered) • Some shots need to be approved in advance. • You do not need a referral. • You can see any provider who will bill us for this service. <p>Well Child Visits</p> <ul style="list-style-type: none"> • From birth to age 2, your child is covered for nine visits. • From age 2 to 18, your child is covered for one visit a year. |
| Death with Dignity (assisted death for terminally ill) | <p>Covered by the OHP. Please call OHP for more information. Services must be performed by a licensed physician or psychologist.</p> <p>Covered Services:</p> <ul style="list-style-type: none"> • The medical confirmation of the terminal condition; • The two visits in which the member makes the verbal request; • The visit when the member makes the written request; • The visit when the prescription is written; • Counseling appointments; and medication/ dispensing. |

Benefits Chart

| Covered Benefits | | |
|--|---|--|
| 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 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: <ul style="list-style-type: none"> • 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 required prescription medications ordered by the dental provider. | | |

| Covered Benefits | Benefit Details |
|---|--|
| Diagnostic and Medical Studies | <p>Some exams, such as MRIs and PET scans, need to be approved in advance.</p> <p>We cover lab and x-ray services when your PCP or treating specialist orders them.</p> |
| Dialysis | You do not need a referral or pre-approval for this service. |
| Drug and Alcohol Treatment | <p>We cover:</p> <ul style="list-style-type: none"> • Office visits and treatment. • Detoxification services (when medically necessary). • Residential treatment. |
| Durable Medical Equipment (DME) and Supplies | <p>Some equipment and supplies need to be approved in advance. Please call Customer Service to find out which items need approval in advance.</p> <p>DME may be covered if it is approved for treatment of a covered illness or injury.</p> <p>The following are some examples of DME covered without approval in advance:</p> <ul style="list-style-type: none"> • Oxygen and oxygen equipment/supplies. • Diabetic supplies, such as glucose test strips (subject to quantity limits) with prescription. |
| Emergency Room Visits | We cover emergency care within the United States. |
| Eye Care | <p>Benefits for members who are not pregnant and age 21 and older.</p> <p>Your PCP may refer you to a specialist. Services and treatment may need to be approved in advance. Eye exams and glasses are only covered if you have an eye injury or have been diagnosed with one of the following conditions:</p> <ul style="list-style-type: none"> • Aphakia • Pseudo Aphakia • Congenital Aphakia • Keratoconus • Congenital Cataracts • Corneal Transplant <p>If you have an eye injury or have been diagnosed with one of the conditions listed above, eye exams and glasses are covered every 24-months.</p> <p>IMPORTANT!</p> <p>We will pay for basic glasses, but if you want to buy more expensive glasses, you will need to pay the full price. We can't pay the difference between the cost of basic glasses and the cost of more expensive glasses.</p> |

Benefits Chart

| Covered Benefits | Benefit Details |
|-------------------------------|---|
| <p>Family Planning</p> | <p>Family planning is a service to prevent or delay a pregnancy. Medical and surgical procedures may only be covered when performed by an in-network (contracted) provider.</p> <p>We cover:</p> <ul style="list-style-type: none"> • Woman’s annual exam. • Birth 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. <p>Related services that are also covered include:</p> <ul style="list-style-type: none"> • Pap tests. • Pregnancy tests. • Screening and counseling for sexually transmitted diseases (STDs), including AIDS and HIV. • Abortions (Contact OHA (formerly DMAP) at: (503) 945-5772, toll-free at (800) 527-5772 or TTY/TDD 711 for more information). <p>IMPORTANT! Hysterectomies are not covered as a part of family planning.</p> |
| <p>Hearing Exams</p> | <p>In a 12-month period, you are eligible for:</p> <ul style="list-style-type: none"> • One basic hearing test. • One comprehensive hearing test. • One hearing aid evaluation and selection. • One electroacoustic evaluation for hearing aid monaural. • One pure tone hearing (threshold) test; air bone. |
| <p>Hearing Aids</p> | <p>Services must be approved in advance.</p> <ul style="list-style-type: none"> • We cover up to 60 batteries per year. To be covered, you need to meet the hearing aid pre-approval requirements. <p><u>Adults:</u> If you meet pre-approval requirements, you may be covered for a single hearing aid every five years.</p> <ul style="list-style-type: none"> • If you have vision limitations and meet pre-approval requirements, you may be eligible for up to two hearing aids. <p><u>Children under age 20:</u> If you meet pre-approval requirements, you may be covered for one hearing aid for each ear every three years.</p> |

| Covered Benefits | Benefit Details |
|--|--|
| Home Health Care | <p>Services must be approved in advance.</p> <p>Examples include: home health aide services, occupational therapy, physical therapy, skilled nursing, speech therapy.</p> |
| Hospice (care for terminally ill) | <p>Hospice Services should be billed to PacificSource Community Solutions. If the member is a resident of a Nursing Facility, the Nursing Facility should bill OHP.</p> <p>Services may include: nursing, medical social services or physician services.</p> <p>Covered when the following criteria are met:</p> <ul style="list-style-type: none"> • Services are reasonable and necessary for managing pain and discomfort caused by the terminal illness and related conditions. • The member chooses hospice care. • A plan of care that includes hospice needs to be established before the services are provided. • The member's doctor must sign a statement that the member is terminally ill. |
| Hospital Care | <p>Services must be approved in advance for treatment of a covered illness or injury.</p> |
| Intensive Care Coordination Services (ICCS) | <p>Coordination of special services for members who have special needs or disabilities. See page 24 for more information.</p> <p>These services can help you:</p> <ul style="list-style-type: none"> • 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. |
| Intensive Community Based Treatment and Support Services (ICTS) | <p>ICTS services are special behavioral health services for children.</p> <p>See Behavioral Health Services section for more information.</p> |
| Interpreter Services | <p>This is a free service.</p> <p>See page 20 for more information.</p> |

Benefits Chart

| Covered Benefits | Benefit Details |
|--|---|
| Maternity Services (Pregnancy care) | <p>We cover:</p> <ul style="list-style-type: none"> • Prenatal care (care for you before your baby is born). • Labor and delivery. • Postpartum care (care for you after your baby is born). • Care for your newborn baby until he or she is 1 year old. <p>For pregnant members age 21 or older:</p> <ul style="list-style-type: none"> • Eye exams and new glasses are covered every 24 months. (Glasses with a prescription equal to or less than +/- .25 diopters in both eyes are not covered). |
| Office Procedures | <p>Services must be approved in advance for treatment of a covered illness or injury.</p> <p>Example: Biopsies</p> |
| Substance Use Disorder Treatment | See Drug and Alcohol Treatment. |
| Preventive Services | |
| Annual Physical | Covered once per year for all ages. |
| Colon Cancer Screening | <p>We also cover additional screenings if your doctor recommends them.</p> <p>For members who are age 50 and older:</p> <ul style="list-style-type: none"> • Fecal occult blood testing covered once every 12-months. • Colonoscopies are covered every 10 years. |
| Mammograms | Covered once every 12-months for women who are age 40 and older. |
| Pap Tests, Pelvic Exams and Clinical Breast Exams | <p>You can see any provider and do not need to be referred by your primary care provider (PCP).</p> <ul style="list-style-type: none"> • 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). |
| Prostate Cancer Screening | Digital rectal exam covered once per year. |
| Physical Therapy/Occupational Therapy | <p>Services must be approved in advance for treatment of a covered illness or injury.</p> <p>Initial evaluations and re-evaluations do not require pre-approval, but are limited to:</p> <ul style="list-style-type: none"> • Up to two initial evaluations in a 12-month period. • Up to four re-evaluations in a 12-month period. |

| Covered Benefits | Benefit Details |
|---|---|
| Prescription Drugs | See Medications section for information. |
| Primary Care Provider (PCP) Visits | <p>Some treatments at your PCP's office must be approved in advance.</p> <p>We cover:</p> <ul style="list-style-type: none"> • Office visits and treatments. |
| Rides to Healthcare Appointments | <p>See Transportation Services section for information.</p> <p>This is a free service.</p> |
| Shots | <p>You can see any provider that accepts your ID card for this service. You do not need to be referred by your primary care provider (PCP).</p> <p>Certain shots are covered like flu and preventive shots. Please call Customer Service if you have questions on which shots are covered.</p> <p>Not covered for travel or employment purposes.</p> |
| Skilled Nursing Facility | <p>Must be medically necessary. Services must be approved in advance.</p> <ul style="list-style-type: none"> • 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 | <p>These services may be covered if they are approved for treatment of a covered illness or injury.</p> <p>All services must be approved in advanced except for the services listed below:</p> <ul style="list-style-type: none"> • 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. |
| Specialty Care (Office Visits & Clinics) | <p>Services must be approved in advance for treatment of a covered illness or injury.</p> <p>You must be referred by your PCP to see a specialist, unless it is for women's routine, preventive healthcare or maternity services.</p> |

Benefits Chart

| Covered Benefits | Benefit Details |
|--|---|
| Stop Smoking/Tobacco Cessation Services | 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. |
| Surgery | Services must be approved in advance. This service may be covered if it is approved for treatment of a covered illness or injury. |
| Urgent Care Visits | Services do not require pre-approval. Services are covered 24-hours a day, 7 days a week, at home or if you are traveling outside the service area. |

Getting Care When You Need It

PacificSource Community Solutions works with the State of Oregon to provide health insurance to people enrolled in the Oregon Health Plan (OHP) who live in Wasco and Hood River counties.

Your Member Handbook

Please take time to look over this handbook and save it so you can check it later if you have questions. This handbook will help you understand the Oregon Health Plan insurance that is provided for you by 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?

In Oregon, the Medicaid program is called the Oregon Health Plan (OHP). Medicaid is a health care program for low-income people that is paid for by the federal and state government.

OHP covers doctor visits, prescriptions, hospital stays, dental care, mental health services, and help for addiction to cigarettes, alcohol, and drugs. In some cases, OHP can provide glasses, hearing aids, medical equipment, home healthcare, and transportation to healthcare appointments.

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 type of managed care. The Oregon Health

Authority (OHA) wants OHP members to have their healthcare managed by private companies set up to do just 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 choose to receive 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 case worker about the best way to receive your medical care. If you don't have a caseworker, call OHP at (800) 699-9075.

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. Please talk to your case worker or enrollment assister about the best way to receive your healthcare. You can also call OHP at (800) 699-9075.

Getting Care When You Need It

Community Advisory Council (CAC)

Each coordinated care organization has its own Community Advisory Committee, also known as the Community Advisory Council (CAC), made up of members like you, providers and other community members. Our Council provides advice and recommendations to us about member and community needs.

The Council is your voice in the health plan. Most Council members (more than half) are PacificSource Community Solutions members. The Council gives you the chance to take an active role in improving your own health and that of your family and community members.

Our Council works to improve the service we and our provider organizations offer members. The Council identifies opportunities to improve and makes suggestions about our programs.

The Council advises us about how to respond to members' needs and plan for community health. It makes recommendations about 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 recruited to represent the diversity of the Columbia Gorge community.

For more information about joining, visit: www.cghealthcouncil.org

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

We want you to get the best care possible. To do that, we ask our providers to be recognized by the Oregon Health Authority as a Patient-Centered Primary Care Home (PCPCH). That

means they receive extra funds to pay more attention to their patients. This helps make sure all their medical and mental health needs are met. You can ask at your clinic or provider's office if it is a PCPCH.

Your Provider Directory

When we sent you this member handbook, we also sent you a Provider Directory. This is a list of all of the doctors, hospitals and other facilities that we contract with. For the most up to date list, you can call Customer Service or go to www.CommunitySolutions.PacificSource.com to search for doctors or other healthcare providers.

Unless it is clearly noted in this handbook, the services you receive 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 in this handbook.

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

If you need another Provider Directory or want to check and see if a provider is in-network and accepting new patients you can call Customer Service or check our online directory at: www.CommunitySolutions.PacificSource.com

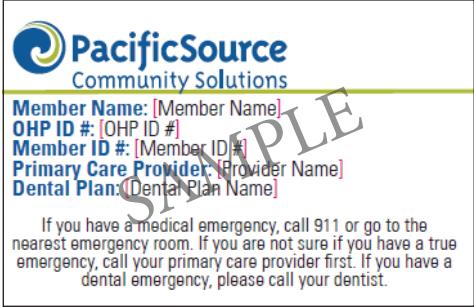
Your Member ID card

You will get two member ID cards within 14 days after enrolling.

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



Below is an example of your PacificSource Community Solutions ID card. Keep this ID card with you at all times.



Take your PacificSource Community Solutions ID card with you to all of your healthcare appointments and when you fill your prescriptions.

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 coverage letter for everyone in your household when you are approved for coverage. Keep this letter in a safe place at home.

The letter tells you your:

- Caseworker name and phone number
- Covered Benefits
- Co-pay (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 women during their pregnancies. 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 at toll-free (800) 431-4135 for help.

Getting Care When You Need It

As soon as possible after your baby is born:

Call your caseworker, enrollment assister or OHP Customer Service to enroll your baby in OHP. When you call, you'll need to provide your baby's:

1. Name
2. Social Security number
3. Date of Birth
4. Parents' names
5. Gender

Once you have enrolled 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.

Your Right to an Interpreter

It is your legal right to have 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. This is a free service. When you call for 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, in most cases you will need to call your provider at least five days before your appointment. 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. Your caseworker's phone number is on page two of your coverage letter. If you don't have a caseworker, call Oregon Health Plan Customer Service at (800) 699-9075.

Access to Benefits

If at anytime 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.

Physical Health Services and Benefits

Your 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 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. 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.

Changing Your PCP

If you would like a different PCP than the one on your Member ID card, please call Customer Service. They have the most current information on which providers are adding new patients.

Call Customer Service and tell them you want a new PCP. You can change your PCP any time of the month up to twice per year, some exceptions may apply.

After you choose a new PCP, we will mail you a new Member ID card. The card shows the name of the new PCP you chose. You will need to talk to your new PCP about any referrals and pre-approvals.

IMPORTANT!

You must call us to change your PCP.

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.

Urgent Care Services

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 pre-approval. Always call your PCP's office before you go to an urgent care clinic. You can call 24-hours a day, 7 days a week.

Do not wait until after office hours to get care. Routine care for sore throats, colds, flu, chronic back pain, tension headaches, and routine counseling appointments, for example, are not urgent care conditions. Take care of problems before they become serious. Services that can be planned ahead of time are not considered urgent.

IMPORTANT!

Do not go to an urgent care office for care that should take place in your PCP's office.

Benefits and Services

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 pre-approval 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.

IMPORTANT!

Do not go to the emergency room for care that should take place in your doctor's office.

Routine care for sore throats, colds, flu, back pain, and tension headaches, for example, are not considered emergencies. Take care of problems before they become serious. Call

your doctor or clinic when you are sick. Please do not wait until after office hours to get care.



Post-Stabilization Care

Post-stabilization care is the care you get after an emergency and after your condition is stable. 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 approval 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.

Emergency Care Away From Home

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.

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: www.Oregon.gov/oha/herc/Pages/PrioritizedList.aspx.

The diseases and conditions below the cut-off are not usually covered by OHP. These are called “below-the-line” conditions. Something that is below-the-line could be covered if you also have a condition that is above-the-line that could get better if your below-the-line condition is treated.

OHP covers services for finding out what’s wrong. 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.

Pre-Approvals

Some services need to be approved by the plan before you get them. This is called pre-approval. 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 pre-approval by calling Customer Service or visiting www.CommunitySolutions.PacificSource.com.

Specialist Care and Referrals

You must have a referral to see most specialists. Your PCP will give you a referral if your PCP decides you should see a specialist.

Here is a list of services that do not need a referral from your PCP:

- Annual women’s exam
- Anticoagulation office visits
- Certain shots
- Dialysis
- Emergency care
- Family planning services (may be given by any provider)
- Health department services
- Intensive Care Coordination Services (ICCS) (for your first visit)
- Lactation services (help with breast feeding your baby)
- Members in the special needs rate group A (example: HIV)
- Maternity care (a referral from your PCP is needed to see a specialist other than your maternity doctor)
- Mental healthcare
- Routine vision exams (only available to children and pregnant women)
- School-based health center services
- Substance use disorder treatment services
- Urgent care

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 www.CommunitySolutions.PacificSource.com and search for a doctor.

IMPORTANT! If you see a specialist without a referral from your PCP, the plan may not pay for your care. You may be billed for those services.

Seeing Out-of-Network Providers:

- You need pre-approval 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.

Second Opinions

If you want a second opinion, ask your PCP to refer you to another provider. Second opinions require a pre-approval from us. We cover one second opinion, at no cost to you.

Flexible Services

Flexible services are health related services that may be provided to improve member health. These services can include but are not limited to equipment, appliances, classes or special clothing or footwear. To find out if you are eligible and for more information about flexible services, please call Customer Service at (800) 431-4135.

Intensive Care Coordination Services (ICCS)

Intensive Care Coordination Services can help you if you are disabled, or if you have:

- Multiple chronic conditions
- High healthcare needs
- Special healthcare needs

ICCS 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.

Call us and we will help put you in touch with a PacificSource staff member who is specially trained to meet your particular need.

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, non-covered model).
- Circumcisions.
- 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 pre-approved.
- 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 non-covered services. However, you will have to pay for them. Before receiving any non-covered service, you and your provider must agree in writing that you will pay for the service.

Transportation Services

Getting a Ride to a Healthcare Appointment

The Transportation Network helps Oregon Health Plan (OHP) members get to their healthcare appointments. The program is called Non-Emergency 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.
- Stretcher vehicle or non-emergent ambulance.
- Reimbursement for driving yourself (if you tell us before the appointment).

Please note, some rules may apply.

For more information call Monday - Friday, 7:00 a.m. to 5:00 p.m. at:

- (877) 875-4657 Toll-free
- (800) 735-2900 TTY

Who Can Get a Ride

You are eligible for a free ride to your covered appointment if:

- You are on OHP and enrolled with PacificSource.
- Your appointment is for something that OHP pays for.
- You can't find any other way to get to the appointment.
- Children ages 12 and under must travel with a parent or guardian who is at least 18 years old.

How to Schedule a Ride

Call The Transportation Network as soon as you schedule your medical appointment. Same-day and next-day rides requests may be approved for:

- Hospital discharges;
- Rides to your Primary Care Provider (PCP) for treatment of a serious illness, or
- Rides to a specialist when your PCP refers you for a next available appointment.

Reimbursements

If you or someone else drives you to your appointment, you may be able to be paid back for part of the cost of the mileage. This is from your home to your appointment and back. If you want to be paid back, you must report this to The Transportation Network before your appointment.

If the ride is urgent and The Transportation Network is closed, you can be paid back for mileage, hotel and food expenses if you send in the papers within 45 days.

Please note, some rules may apply.

Behavioral Health Services

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

These services are available to everyone. You do not need a referral from your doctor to get in-network Behavioral Health services.

Behavioral Health treatment services include:

- Case management
- Consultations
- Counseling
- Crisis services
- Evaluations
- 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

Access to Behavioral Health Services

You can get help with depression, anxiety, and problems with alcohol and drugs. A good first step is to get a mental health evaluation. This will help figure out what kind of help you may need. These services are available through the county Community Mental Health Programs (CMHP). They are also available through any in-network provider found in the provider directory.

Our provider directory can be found at: www.CommunitySolutions.PacificSource.com/Tools/ProviderDirectory.

Phone Numbers for Community Mental Health Programs (CMHP) by county.

Hood River County

Mid-Columbia Center for Living
1610 Woods Court
Hood River, OR 97031

- (541) 386-2620
- (800) 735-2900 TTY

Wasco County

Mid-Columbia Center for Living
419 East 7th Street
The Dalles, OR 97058

- (541) 296-5452
- (800) 735-2900 TTY

Mental Health Regional Crisis Line

(Available after hours)

- (866) 877-9147 Toll-free
- (800) 735-2900 TTY

Mental Health Assessment and Treatment Planning

Members are covered for a complete mental health evaluation. You can get an evaluation from your local CMHP or in-network provider. You can also get one from an approved primary care clinic with combined Behavioral Health services. The completed evaluation will be used to decide what the right treatment is for you. Members with complex needs are generally best served by the local CMHP.

How to Change Your Behavioral Health Provider

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

Behavioral Health Services in the Primary Care Setting

- You can get routine behavioral health services directly from our in-network providers.
- You are not required to have a referral from your primary care provider (PCP) or a pre-screening from our assigned Community Mental Health Program to get routine behavioral health services.
- Many primary care offices will offer Behavioral Health services.

Applied Behavioral Analysis Therapy

Applied Behavioral Analysis Therapy (ABA) is a service for Autism. Before a member can be referred to ABA, they must have an evaluation with a licensed mental health provider who has had training in the diagnosis of Autism. Please talk with your provider about a referral for ABA services, or call our Customer Service department for help.



Behavioral Health Crisis Services

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

A crisis is when you feel like you might harm yourself or others, or anything that needs attention immediately. These are covered services that are needed to keep a person's mental health from getting worse. Behavioral health crisis or emergency behavioral health care is covered 24 hours a day, 7 days a week. You do not need pre-approval.

If you do not have a primary care or Mental Health doctor, please call our Mental Health Crisis line:

- (888) 877-9147 Toll-free
- (800) 735-2900 TTY

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

Important!

You do not need to get approval 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
- Call the Community Mental Health Program (CMHP) in your area
- Call us for help

Substance Use Disorder Residential Treatment

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

If you need help for a substance use disorder, there are many ways to get the help you need. You can talk to your primary care provider (PCP) or a mental health doctor. You can also call the Community Mental Health Program (CMHP) or our Customer Service department. You may see any in-network drug and alcohol/substance use disorder treatment provider in our network without a referral.

For residential services, you can call BestCare Treatment Services or Rimrock Trails Adolescent Treatment Services directly. BestCare serves adults age 18 or older, and Rimrock Trails serves adolescents ages 12-17 years old.

Choice Model Services and ISA 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.

Choice Model Services and ISA are managed by your county's Community Mental Health Program. If you want more information about these programs, give them a call.

Intensive Community-Based Treatment and Support Services (ICTS)

ICTS services are special behavioral health services for children. This is a trained team of behavioral health providers and case managers working together. They help families with children deal with trauma, substance abuse, depression, anxiety, juvenile justice, parent/child relationships, and other behavioral health needs. In many cases it is available through the CMHP. They will help you find the best services for your child.

Dental Health Services

Oral health is part of overall health. The Oregon Health Plan covers prevention and treatment dental health 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 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

www.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

www.CapitolDentalCare.com

ODS Community Health

Customer Service:

(800) 342-0526 Toll-free

TTY users call 711

www.ModHealth.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 toll-free at (800) 431-4135. TTY users call (800) 735-2900.

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, at no cost to you. If you want a second opinion, ask your PCD to refer you to another provider. You will need to get approval if you want to see someone outside of your dental plan's network.

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. Emergency services do not require pre-approval.

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

If you need urgent care, 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 cannot reach them, call your dental plan and they will help you get an appointment.

Medications

PacificSource Community Solutions covers prescription drugs for conditions paid for by the Oregon Health Plan. Family planning drugs, some over-the-counter (OTC) products, and some devices are also covered. OTC products are listed on the formulary. You still need a prescription from your provider before we can pay for an OTC drug.



Formulary

PacificSource uses a formulary. A formulary is a list of drugs that are covered by PacificSource. Pharmacists and doctors decide which drugs should be in the formulary.

The formulary may change. Sometimes we add, remove or change the coverage requirements on drugs. If we take a drug off the formulary or add restrictions to a drug that you are taking, we will tell you before it happens.

If you are a new member, please call us to find out if the drugs you take are on the formulary or have special coverage restrictions.

If you want a copy of the formulary or have questions, call Customer Service. You can also see the formulary online at: www.CommunitySolutions.PacificSource.com

If you can't see your provider before you run out of a medication you are currently taking, you can ask for a temporary exception. Please have your provider call our Pharmacy Services department toll-free at (888) 437-7728.

Coverage Limitations

These drugs are not covered:

- Drugs not listed on the formulary.
- Drugs used to treat conditions that are not covered by the OHP. Examples include fibromyalgia, allergic rhinitis, epidural steroid injections and acne.
- Drugs used for cosmetic purposes.
- Drugs that are not approved by the U.S. Food and Drug Administration (FDA).
- Drugs that have little or poor scientific evidence to support their use.
- 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.

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

Getting Your Prescriptions

PacificSource works with a network of pharmacies. These include most pharmacy chains. If you need to find an in-network pharmacy or have questions, call Customer Service. You can also find a list of in-network pharmacies on our website:
www.CommunitySolutions.PacificSource.com

When picking up your prescriptions, show the pharmacy your PacificSource Member ID card so they will know where to send the bill.

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 “non-formulary.” 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 pre-approval. 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. 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 at:
www.CommunitySolutions.PacificSource.com.

The provider can also call our Pharmacy Services department toll-free at (888) 437-7728 with any questions.

Billing Information

OHP Members Don't Pay Bills For Covered Services.

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.

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 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.

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 toll-free at (800) 431-4135, or TTY at (800) 735-2900 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 Hot line 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 that came with this handbook or by searching online at www.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 generally make payment on claims only when other means are not available for your medical needs.

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 co-pays for Part D drug coverage. Some duals have their co-pays 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 non-emergency.

Other Things You Should Know

Disenrollment

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

- (800) 431-4135 Toll-free
- (800) 735-2900 TTY

Your enrollment with the plan could end for several reasons. For example:

- If you lose your OHP eligibility;
- If you move outside of the plan's service area;
- 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 or changing a prescription;
- If you are disruptive or abusive toward the staff at the plan or your provider's office or their property; or
- If you threaten or become physically violent toward your provider or staff.

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 Customer Service at (800) 699-9075. OHP Customer Service will help you find out if a change is possible.

How to Change CCOs

If another CCO is available, you may change at certain times:

- If you didn't choose the CCO you are in, you may change within 30 days of enrolling.
- You may change when your eligibility for OHP is determined, usually once a year.
- Within the first 90 days of entering OHP.
- Once during each enrollment period.
- If you are also on Medicare, you can change or leave your CCO anytime.

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.

As long as 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 www.healthcare.oregon.gov/shiba/topics/Pages/advance-directives.aspx

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 Advanced 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 your provider does not follow your wishes as stated in your Advance Directive, you can call (971) 673-0540 or TTY (971) 673-0372 or send a complaint to:

Health Care Regulation and Quality
Improvement
800 N.E. Oregon St., #465
Portland, OR 97232
Email: mailbox.hclc@state.or.us

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

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 www.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 www.oregon.gov/oha/HSD/amh/forms/declaration.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:

Health Care Regulation and Quality Improvement
800 N.E. Oregon St., #465
Portland, OR 97232
Email: mailbox.hclc@state.or.us

You can find complaint forms and additional information at www.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 health care 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 health care fraud, please contact Customer Service, or visit our website at www.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 Customer Service staff. Call (800) 431-4135. TTY users can call (800) 735-2900.

Send written complaints to:

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

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

Our staff will work to address each of your concerns and resolve them within five business days. If your complaint needs more follow-up, you will receive a call or letter within five business days. We will provide a final answer to you within 30 calendar days.

If you need help with 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, or a qualified community health worker, qualified peer specialist, or a personal health navigator help you. A provider cannot act as your representative for filing a grievance.

You need to give us permission to investigate and help you resolve the issue. Please note that we will not tell anyone anything about your complaint unless you ask us to. If you are not happy with our answer, you can also file the complaint with the Oregon Health Authority (OHA) Ombudsperson. You can call them at (503) 947-2346, or toll-free at (877) 642-0450. The TTY number is 711. Their fax number is (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 Action."

In order to process your appeal, we must have it in writing. Your Notice of Action letter will include an appeal form.

Ways to complete the appeal form:

- You or your representative can fill it out.
- You can call Customer Service and we will fill it out for you and send it to you to sign.
- Your provider 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 toll-free at (800) 431-4135, or TTY at (800) 735-2900. 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: Grievance and Appeals
PO Box 5729
Bend, Oregon 97708

You can also fax it to (541) 322-6424.

Complaints and Appeals

Before you send in the appeal form:

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

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.

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.

A qualified healthcare reviewer will look at your healthcare records and decide if we should make a fast decision.

If we agree that it is urgent, we will call you (if possible) with a decision within 3 days (72 hours).

If we decide that you do not qualify for a fast appeal, your appeal will be processed normally and you will receive a response within 16

calendar days.

For both standard and 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.

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.

Please note: If your provider files the appeal and if the decision is still to deny coverage, he or she will not have the right to act as your authorized representative for an Administrative Hearing. Having a provider file an appeal on your behalf does not mean that your 60 day time frame to file an appeal will be extended.

Oregon Health Authority Administrative Hearings

When you receive a denial letter from us, you or your representative also have the option to ask for an Administrative Hearing through the State. If you file an appeal and are still not satisfied with the results, you or your representative may ask for an Administrative Hearing.

Your Notice of Action denial 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 (Notice of Action or Notice of Appeal Resolution, whichever is later).

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

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 (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.

You do not need to hire a lawyer, but you can have one or someone else help you with the hearing. 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, but it cannot be your provider.

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 www.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 continue benefits within 10 calendar days of the date on the 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 approval 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:

1. You cancel the appeal or hearing;
2. The appeal decision or final order on the hearing is not to your benefit; or
3. 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.

Complaints and Appeals

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 to have your written permission to do so. There is a form they can use located on our website, at: www.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.

Member Rights and Responsibilities

Member Rights

- To be treated with dignity and respect.
- To be treated by providers the same as other people seeking healthcare benefits to which you are entitled.
- To get covered mental health, substance use treatment, family planning, or related services without a referral.
- To have a friend, family member, or advocate with you during appointments and at other times as needed within clinical guidelines.
- To be actively involved in making a treatment plan.
- To get information about your condition and covered and non-covered services, to allow an informed decision about proposed services.
- To agree to or refuse services except for court-ordered services.
- To be told the results of agreeing or refusing services.
- To get written materials describing rights, responsibilities, and benefits available.
- How to get services, and what to do in an emergency.
- To get written materials explained in a manner that can be understood.
- To get necessary and reasonable services to diagnose the presenting condition.
- To get covered services under OHP which meet generally accepted standards of practice and are needed. To get covered preventive services.
- To get a referral to a specialist for needed, covered services.
- To have a clinical record maintained which documents conditions, services received and referrals made.
- To have access to your own clinical record, unless restricted by law or OARs. (Oregon Administrative Rules).
- To have your medical records corrected.
- To transfer a copy of your clinical record to another provider.
- To make a statement of wishes for services (Advance Directive) and get a power of attorney for healthcare.
- To get written notice before a denial of, or change in, a service level or benefit is made unless such notice is not required by federal or state OARs.
- To know how to make a complaint, grievance or appeal and get a response.
- To request an administrative hearing with the DHS or OHA.
- To get a notice of an appointment being cancelled in a timely manner.
- To get adequate notice of DHS/OHA privacy practices.
- Select or change your provider.
- Have the plan's written materials explained so you can understand it.
- Make complaints and not be treated bad by the plan or provider.
- Get care when you need it, 24-hours a day, seven days a week.
- Be able to limit who can see your health records.

Member Rights and Responsibilities

- Help 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.

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 living environment;
- To a humane service environment that has;
- Reasonable protection from harm;
- Reasonable privacy;
- Daily access to fresh air and the outdoors;
- To keep and use personal clothing and belongings;
- To have enough private, secure storage space;
- To express sexual orientation;
- Gender identity and gender presentation;
- To get to and participate in social, religious and community activities;
- To private and uncensored communications by mail, telephone and visitation, subject to the following restrictions:
 - This right may be restricted only if the provider documents in the individual's record that there is a court order that says something else, or
 - That in the absence of this restriction, significant physical or clinical 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 correspondence:
 - Can be conveniently received and mailed,
 - That telephones are reasonably able to use and allow for confidential communication. (Reasonable times for the use of telephones and visits may be established in writing by the provider)
 - That space is available for visits.
 - To have access to and get available applicable educational services in the most integrated setting in the community.
 - To communicate privately with public or private rights protection programs or rights advocates, clergy, and legal or medical professionals.
 - To participate regularly in indoor and outdoor recreation.
 - To not be required to perform labor.
 - To have enough food and shelter.
 - To a reasonable accommodation if, due to a disability, the housing and services are not sufficiently accessible.

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 reduce the use of referrals and or other services that you might need. To get this information, call our Customer Service Department, 8:00 a.m. to 5:00 p.m., Monday through Friday toll-free (800) 431-4135. TTY users should call (800) 735-2900. Ask for information about our provider payment arrangements.

PacificSource Community Solutions Business Structure and Operations

You have the right to ask about the structure of PacificSource Community Solutions and how it operates. This information tells you who we are, how the company is set up, and who is in charge. To get this information, call our Customer Service Department 8:00 a.m. to 5:00 p.m., Monday through Friday toll-free (800) 431-4135. TTY users should call (800) 735-2900. Ask for information about our company structure.

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 choose or help us assign you to a behavioral health provider.
- 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 in advance to cancel if you are not able to make it or if you are running late.
- To tell your provider of your behavioral health problems.
- To decide about care before you receive it.
- To get behavioral health services from in-network providers. You may get services from an out-of-network provider only in an emergency.
- To call PacificSource Community Solutions Customer Service to tell us if you had an emergency within three days.
- To use only your assigned behavioral health provider for your behavioral health needs.
- To get regular health exams and preventive services from your providers.
- To have yearly check-ups, wellness visits and other services to prevent illness and keep you healthy.
- To use your PCP or clinic for diagnostic and other care except in an emergency.
- To get a referral from your PCP before going to a specialist.
- To use urgent and emergency services appropriately.
- 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.

Member Rights and Responsibilities

- 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 case worker if you change your address or phone number.
- To tell your case worker if you become pregnant, let him or her know when you are no longer pregnant or when your baby is born.
- To tell your case worker if any family members move in or out of your house.
- To tell your case worker 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.

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:
www.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.
- Worker’s Compensation. We may disclose PHI as allowed by law to worker’s 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 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: Grievance/Appeals
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 have any questions please call Customer Service.

Nondiscrimination Statement

PacificSource and network providers must treat you fairly. Our providers and we must follow state and federal civil rights laws. We cannot treat people unfairly in any of our services or programs because of a person's:

- Age
- Color
- Disability
- Gender Identity
- Marital Status
- National Origin
- Race
- Religion
- Sex
- 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:

- Sign language interpreters
- Spoken language interpreters for other languages
- Written materials in other languages
- Braille
- Large print
- Audio and other formats

If You Need Help

If you need help or have a concern, please contact our Customer Service department or our Civil Rights manager toll-free Monday - Friday, 8:00 a.m. - 5:00 p.m. at:

Customer Service Department

- (800) 431-4135 Central Oregon
- (855) 204-2965 Columbia Gorge
- (800) 735-2900 TTY

Civil Rights Manager

Kristi Kernutt

- Phone: (541) 225-1967, (800) 735-2900 TTY
- Email: Kristi.Kernutt@pacificsource.com
- Mail: PO Box 7068
Springfield, OR 97475-0068

To File a Complaint

To file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights (OCR):

- Web: www.HHS.gov/Civil-Rights/For-individuals/Section-1557/Translated-resources
- Email: OCRComplaint@hhs.gov
- Phone: (800) 368-1019
(800) 537-7697 (TDD)
- Mail: OCR
200 Independence Avenue SW
Room 509F, HHH Bldg.
Washington, DC 20201

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.

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

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.

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.

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

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

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.

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

العربية (Arabic): لصلتا. ن اجم اب لكل رفاوتت ةىوغلل ادعاسملا تامدخ نإف، ةغلل ركذا ثدحتت تنك اذ: ةظوحلم ةىبرعلا ه مصلا مكبل او. 5314-134-(008), 0092-537-(008) TTY:

ภาษาไทย (Thai): เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (800) 431-4135, (800) 735-2900 TTY.

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.

ខ្មែរ (Cambodian): ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្លូវភាសា ដោយមិនគិតលុយ គឺអាចមានសំរាប់ប្រើអ្នក។ ចូរ ទូរស័ព្ទ (800) 431-4135, (800) 735-2900 TTY.។

Cushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa (800) 431-4135, (800) 735-2900 TTY.

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

فارسی (Farsi): امش یارب ناگیار تروصب ینابز تالی هست، دینک یم وگتفگ یسراف نابز هب رگا: هجوت (800) 431-4135, (800) 735-2900 TTY.

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.

Customer Service

Toll-free:

(800) 431-4135

TTY/TDD:

(800) 735-2900

2965 NE Conners Avenue
Bend, Oregon 97701

www.CommunitySolutions.PacificSource.com

Office Hours:

Monday through Friday 8:00 a.m. to 5:00 p.m.

Our offices are wheelchair accessible.