2024 Member Handbook

Last updated July 01, 2024

3031 NE Stephens St. Roseburg, OR 97470

Customer Care: 541-229-4UHA or 541-229-4842

Toll-free: 1-866-672-1551 l TTY 541-440-6304

UHCustomerCare@umpquahealth.com

www.umpquahealth.com

OHP-UHA-23-080

Handbook Updates

Umpqua Health Alliance (UHA) mails a member handbook to newly enrolled or reenrolled members when Oregon Health Authority (OHA) notifies us that you are enrolled in Oregon Health Plan (OHP), as is required by federal law. Here is where you can find the most up to date handbook www.umpquahealth.com/benefits/. If there are updates to your UHA benefits, you will be receiving a written letter no later than 30 days before the change is effective. If you need help or have questions, call Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711.

Getting Started:

You will be receiving a survey in the mail that will help UHA know how to support you with your physical, behavioral, and oral health care needs. Here is a link of what the survey looks like www.umpquahealth.com/case-management/. To learn more about this survey, go to page 29.

Complete and return your survey in any of these ways:

- Phone: 541-229-4842, TTY 541-440-6304 or TTY 711
- Fax: 541-229-8180
- Mail: Umpqua Health Alliance
  3031 NE Stephens St
  Roseburg, OR 97470
- Email: CaseManagement@umpquahealth.com
- Web: www.umpquahealth.com/case-management/

Helpful Tips:

Some UHA members can get extra benefits like FoodSmart, Iris Advanced Care Planning, and trips to the grocery store and farmer's markets. Call UHA to find out more.

Refer to the end of handbook for definition of words that may be helpful to know.

If you are looking for:

- **Rights and Responsibilities:** Go to pages 21-25
- **Primary Care Providers:** Go to pages 26-27
- **Care Coordination:** Go to pages 29-34
- **Benefits:** Go to page 34, and pages 38-60
- **Prior Approvals and Referrals:** Go to pages 35-37
- **How long it takes to get care:** Go to pages 66-67
- **Rides to Care:** Go to pages 75-79
- **Prescriptions:** Go to pages 80-82
- **Emergency Care:** Go to pages 84-89
- **Grievances, Complaints and Appeals:** Go to pages 101-107

Always carry your OHP and UHA member ID cards with you.

- Note: These will come separately, and you will receive your OHP ID card before your UHA member ID card.

You can find your UHA ID Card in the welcome packet with this member handbook. Your ID card has the following information:

- Your name
- Your ID number
- Your Plan information
- Your Primary Care Provider name and information
- Customer Care phone number
- Language Access phone number

My Primary Care Provider is _____

Their number is _____

My Primary Care Dentist is _____

Their number is _____

Other Providers I have are _____

Their number is _____

My nonemergent medical transportation (free rides to care) is _____

Their number is _____

Free help in other languages and formats

Everyone has a right to know about UHA's programs and services. All members have a right to know how to use our programs and services. We give these kinds of free help:

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

You can find this member handbook on our website at: www.umpquahealth.com/benefits/. If you need help or have questions, call Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711.

Get information in another language or format.

You or your representative can get member materials like this handbook or CCO notices in other languages, large print, Braille or any format you prefer. You will get materials within 5 days of your request. This help is free. Every format has the same information. Examples of member materials are:

- This handbook
- List of covered medications
- List of providers
- Letters, like complaint, denial, and appeal notices

Your use of benefits, complaints, appeals, or hearings will not be denied or limited based on your need for another language or format.

You can ask for materials electronically. Fill out the secure contact form on our website at www.umpquahealth.com/contact-us/. Please let us know which documents you would like emailed to you. You can also call Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711.

You can have an interpreter.

You, your representative, family members and caregivers can ask for a certified and qualified health care interpreter. You can also ask for sign language and written interpreters or auxiliary aids and services. These services are free.

Tell your provider's office if you need an interpreter at your visit. Tell them what language or format you need. Learn more about certified Health Care Interpreters at Oregon.gov/OHA/OEI.

If you need language help, please call us at 541-229-4842, TTY 541-440-6304 or TTY 711 or call OHP Client Services at 800-273-0557 (TTY 711).

If you do not get the interpreter help you need, call the state's Language Access Services Program coordinator at 844-882-7889, TTY 711 or email: LanguageAccess.Info@odhsoha.oregon.gov. You can also file a complaint (grievance) with UHA. See pages 101-107 for "Complaint, appeal and hearing rights."

English

You can get this handbook in other languages, large print, Braille or a format you prefer. You can also ask for an interpreter. This help is free. Call 541-229-4842, TTY 541-440-6304 or TTY 711. We accept relay calls.

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You can get help from a certified and qualified health care interpreter.

Spanish

Puede obtener este documento en otros idiomas, en letra grande, braille o en un formato que usted prefiera. También puede recibir los servicios de un intérprete. Esta ayuda es gratuita. Llame al servicio de atención al cliente 541-229-4842 TTY 541-440-6304 o TTY 711. Aceptamos todas las llamadas de retransmisión.

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Usted puede obtener ayudar de un intérprete certificado y calificado en atención de salud.

Russian

Вы можете получить это документ на другом языке, напечатанное крупным шрифтом, шрифтом Брайля или в предпочитаемом вами формате. Вы также можете запросить услуги переводчика. Эта помощь предоставляется бесплатно.

Звоните по тел. 541-229-4842 TTY 541-440-6304 или (TTY 711). Мы принимаем звонки по линии трансляционной связи.

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Вы можете получить помощь от аккредитованного и квалифицированного медицинского переводчика.

Vietnamese

Quý vị có thể nhận tài liệu này bằng một ngôn ngữ khác, theo định dạng chữ in lớn, chữ nổi Braille hoặc một định dạng khác theo ý muốn. Quý vị cũng có thể yêu cầu được thông dịch viên hỗ trợ. Sự trợ giúp này là miễn phí. Gọi 541-229-4842 TTY 541-440-6304hoặc TTY or TTY 711. (Đường dây Dành cho Người Khiếm thính hoặc Khuyết tật về Phát âm). Chúng tôi chấp nhận các cuộc gọi chuyển tiếp.

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Quý vị có thể nhận được sự giúp đỡ từ một thông dịch viên có chứng nhật và đủ tiêu chuẩn chuyên về chăm sóc sức khỏe.

Arabic

يمكنكم الحصول على هذا وثيقة بلغات أخرى، أو مطبوعة بخط كبير، أو مطبوعة على طريقة برايل أو حسب الصيغة المفضّلة لديكم. كما يمكنكم طلب مترجم شفهي. إن هذه المساعدة مجانية. اتصلو على 541-229-4842, TTY 541-440-6304 or TTY 711أو المبرقة الكاتبة . نستقبل المكالمات المحولة.

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يمكنكم الحصول على المساعدة من مترجم معتمد ومؤهل في مجال الرعاية الصحية.

Somali

Waxaad heli kartaa warqadan oo ku qoran luqaddo kale, far waaweyn, farta dadka indhaha aan qabin wax ku akhriyaan ee Braille ama qaabka aad doorbidayso. Waxaad sidoo kale codsan kartaa turjubaan. Taageeradani waa lacag la’aan. Wac 541-229-4842 TTY 541-440-6304 ama TTY 711. Waa aqbalnaa wicitaanada gudbinta.

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Waxaad caawimaad ka heli kartaa turjubaanka daryeelka caafimaadka oo xirfad leh isla markaana la aqoonsan yahay.

Simplified Chinese

您可获取本文件的其他语言版、大字版、盲文版或您偏好的格式版本。您还可要求提供口译员服务。**本帮助免**费。致电 541-229-4842 TTY 541-440-6304 **或** TTY 711。**我**们会接听所有的转接来电。

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您可以从经过认证且合格的医疗口语翻译人员那里获得帮助。

Traditional Chinese

您可獲得本**信**息函的其他語言版本、大字版、盲文版或您偏好的格式。您也可申請口譯員。以上協助均為免費。請致電 541-229-4842 541-440-6304 或聽障專線 TTY 711。我們接受所有傳譯電話。

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您可透過經認證的合格醫療保健口譯員取得協助。

Korean

이문서은 다른 언어, 큰 활자, 점자 또는 선호하는 형식으로 받아보실 수 있습니다. 통역사를 요청하실 수도 있습니다. 무료 지원해 드립니다. 541-229-4842 TTY 541-440-6304 또는에 TTY 711)전화하십시오. 저희는 중계 전화를 받습니다.

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공인 및 자격을 갖춘 의료서비스 전문 통역사의 도움을 받으실 수 있습니다.

Hmong

Koj txais tau ntaub ntawv no ua lwm yam lus, ua ntawv loj, ua lus Braille rau neeg dig muag los sis ua lwm yam uas koj nyiam. Koj kuj thov tau kom muaj ib tug neeg pab txhais lus. Txoj kev pab no

yog ua pub dawb. Hu 541-229-4842 TTY 541-440-6304 sis TTY 711. Peb txais tej kev hu xov tooj rau neeg lag ntseg.

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Koj yuav tau kev pab los ntawm ib tug kws txawj txhais lus rau tib neeg mob.

Marshallese

Kwomaroñ bōk peba in ilo kajin ko jet, kōn jeje ikkillep, ilo braille ak bar juon wāwein eo eṃṃanḷọk ippaṃ. Kwomaroñ kajjitōk bwe juon ri ukōt en jipañ eok. Ejjeḷọk wōṇāān jipañ in. Kaaltok 541-229-4842 TTY 541-440-6304 TTY 711. Kwomaroñ kaaltok in relay.

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Kwomaroñ bōk jipañ jān juon ri ukōt ekōmālim im keiie āinwōt ri ukōt in ājmour.

Chuukese

En mi tongeni angei ei taropwe non pwan ew fosun fenu, mese watte mak, Braille ika pwan ew format ke mwochen. En mi tongeni pwan tingor emon chon chiaku Ei aninis ese fokkun pwan kamo. Kokori 541-229-4842 TTY 541-440-6304 TTY 711. Kich mi etiwa ekkewe keken relay.

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En mi tongeni kopwe angei aninis seni emon mi certified ika qualified ren chon chiaku ren health care.

Tagalog

Makukuha mo ang papel na ito sa iba pang mga wika, malaking letra, Braille, o isang format na gusto mo. Maaari ka ring humingi ng tagapagsalin. Ang tulong na ito ay libre. Tawagan ang 541-229-4842 TTY 541-440-6304 o TTY 711. Tumatanggap kami ng mga relay na tawag.

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Makakakuha ka ng tulong mula sa isang sertipikado at kwalipikadong tagapagsalin ng pangangalaga sa kalusugan.

German

Sie können dieses Dokument in anderen Sprachen, in Großdruck, in Brailleschrift oder in einem von Ihnen bevorzugten Format erhalten. Sie können auch einen Dolmetscher anfordern. Diese Hilfe ist gratis. Wenden Sie sich an 541-229-4842 per Schreibtelefon an 541-440-6304 TTY 711. Wir nehmen Relaisanrufe an.

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Sie können die Hilfe eines zertifizierten und qualifizierten Dolmetschers für das Gesundheitswesen in Anspruch nehmen.

Portuguese

Esta documento está disponível em outros idiomas, letras grandes ou braile, se preferir. Também poderá solicitar serviços de interpretação. Essa ajuda é gratuita. Ligue para 541-229-4842 use o serviço TTY 541-440-6304 TTY 711. Aceitamos encaminhamentos de chamadas.

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Você poderá obter a ajuda de intérpretes credenciados e qualificados na área de saúde.

Japanese

この書類は、他の言語に翻訳されたもの、拡大文字版、点字版、その他ご希望の様式で入手可能です。また、通訳を依頼することも可能です。本サービスは無料でご利用いただけます。541-229-4842 または TTY 541-440-6304 TTY 711 までお電話ください。電話リレーサービスでも構いません。

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認定または有資格の医療通訳者から支援を受けられます。

Ukrainian

Ви можете отримати цей довідник іншими мовами, крупним шрифтом, шрифтом Брайля або у форматі, якому ви надаєте перевагу. Ви також можете попросити надати послуги перекладача. Ця допомога є безкоштовною. Дзвоніть по номеру телефону 541-229-4842 або телетайпу TTY 711 541-440-6304. Ми приймаємо всі дзвінки, які на нас переводять.

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Ви можете отримати допомогу від сертифікованого та кваліфікованого медичного перекладача.

Our nondiscrimination policy

Umpqua Health Alliance (UHA) and its providers comply with applicable state and federal civil rights laws. We cannot discriminate, exclude, or treat people unfairly in any of its programs or activities because of a person's age, color, disability, gender identity, marital status, national origin, race, religion, sex, or sexual orientation. UHA does not discriminate against people able to enroll based on their health status or need for health care services.

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

UHA provides free aids and services to people with disabilities or who do not speak English as their primary language, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

If you need these services, or if you believe that UHA has failed to provide these services or have been discriminated, excluded, or treated unfairly for any of the above reasons, you can contact the following:

UHA's Appeals and Grievances Coordinator (non-discrimination coordinator) or Customer Care at:

- Phone: 541-229-4842; Toll Free: 866-672-1551; TTY: 541-440-6304 or 711
- Hours: Monday to Friday, 8 a.m.- 5 p.m.
- Fax: 541-677-5881
- Mail: Umpqua Health Alliance, 3031 NE Stephens St, Roseburg, OR 97470
- Website and Complaint Form: www.umpquahealth.com/appeals-and-grievances/
- Email: UHAGrievance@umpquahealth.com

You can also use the contact information above if you need help filing a complaint (grievance).

You can also file a civil rights complaint in your preferred language with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

Oregon Health Authority (OHA) Civil Rights

- Website: oregon.gov/OHA/OEI
- Phone: (844) 882-7889, 711 TTY
- Email: OHA.PublicCivilRights@odhsoha.oregon.gov
- Fax: 971-673-1330
- Mail: Office of Equity and Inclusion Division, 421 SW Oak St., Suite 750 Portland, OR 97204

Oregon Bureau of Labor and Industries Civil Rights Division

- Website: www.oregon.gov/_/civil-rights/Pages/default.aspx
- Phone: 971-673-0764 (voice) or 711 (TTY)
- Email: BOLI_help@boli.oregon.gov

- Mail: Bureau of Labor and Industries Civil Rights Division, 800 NE Oregon St., Suite 1045, Portland, OR 97232

U.S. Department of Health and Human Services Office for Civil Rights (OCR)

- Website: ocrportal.hhs.gov/ocr/smartscreen/main.jsf
- Phone: (800) 368-1019, (800) 537-7697 (TDD)
- Email: OCRComplaint@hhs.gov
  Mail: Office for Civil Rights, 200 Independence Ave. SW, Room 509F, HHH Bldg., Washington, DC 20201

We keep your information private.

We only share your records with people who need to see them. This could be for treatment, business operations, or for payment reasons. You can limit who sees your records. Tell us in writing if you don't want someone to see your records **or** if you want us to share your records with someone. Email us at UHCustomerCare@umpquahealth.com. You can ask us for a list (accounting) of who we have shared your records with.

A law called the Health Insurance Portability and Accountability Act (HIPAA) protects your medical records and keeps them private. This is also called confidentiality. We have a paper called Notice of Privacy Practices that explains how we use our members' personal information. We will send it to you if you ask. Just call Customer Care and ask for our Notice of Privacy Practices. You can also see it at www.umpquahealth.com/services.

Health records

A health record has your health conditions and the services you used. It also shows the referrals that have been made for you.

What can you do with health records?

- Send, or have UHA send, your record to another provider.
- Ask to fix or correct your records.
- Get a copy of your records, including, but not limited to:
  - Medical records from your provider
  - Dental records from your dental care provider
  - Records from UHA

There may be times when the law restricts your access. You may be charged a reasonable amount for a copy of the requested records.

Some records cannot be shared. A provider cannot share records when, in their professional judgement, sharing the records could cause a "clear and immediate" danger to you, others, or to society. A provider also cannot share records prepared for a court case.

What's in this handbook

Call us:
541-229-4842 | Toll-free 866-672-1551 | TTY 541-440-6304
Oregon Relay 711

Email us:
UHCustomerCare@umpquahealth.com

Fax us:
541-677-6038

Visit or write us:
3031 NE Stephens St
Roseburg, OR 97470

Visit our website:
www.umpquahealth.com

Welcome to Umpqua Health Alliance!

We are glad you are part of Umpqua Health Alliance (UHA). UHA is happy to help with your health. We want to give you the best care we can. It is important to know how to use your plan. This handbook tells you about our company, how to get care, and how to get the most from your benefits.

UHA is made up of two groups: Douglas County Individual Practice Associates, Inc. (DCIPA) and Mercy Medical Center, Inc. (MMC). Both groups own UHA as equal (50/50) partners. We serve all people in Douglas County. At your request, we will provide information on the structure and operations of UHA's organizations. We will mail it out to you, free of charge, within 5 business days.

UHA helps members get high quality medical, dental, behavioral health (mental health), and substance use treatment. This is done through local partnerships and innovation. We coordinate your care by asking our providers to be recognized by the Oregon Health Authority (OHA) as a Patient Centered Primary Care Home (PCPCH), or other primary care team. That means they can get extra funds to follow their patients closely. These extra funds will not impact your access to benefits or care. They make sure all your medical, dental, and mental health needs are met. You can ask your clinic or provider's office if they are a PCPCH.

UHA works with other organizations to help manage certain parts of your benefits, such as dental and transportation. For information about these organizations and the services they offer, please see pages 54-60 for dental and pages 75-79 for transportation.

We pay a bonus or reward our providers for keeping you healthy. We do not pay or reward our providers for limiting services and referrals. We will send you more information about provider payments upon your request. We will mail it out to you, free of charge, within 5 business days.

UHA is a Limited Liability Corporation (LLC) under Oregon law. Information about UHA's leadership and the Board of Directors can be found on our website at www.umpquahealth.com/leadership/. The agenda and meeting minutes for the board meetings are also posted here.

How OHP and UHA work together

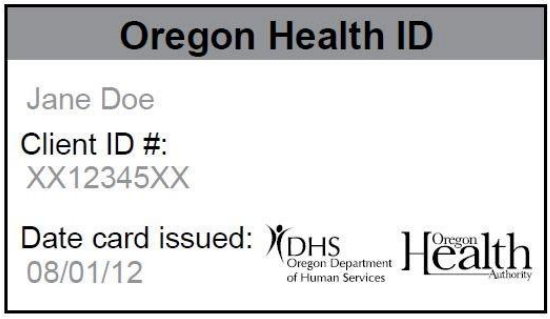
The Oregon Health Plan (OHP) is free health care coverage for Oregonians. OHP is Oregon's Medicaid program. It covers physical, dental, and behavioral health care services (mental health and substance use disorder treatment). OHP will also help with prescriptions and rides to care.

OHP has local health plans that help you use your benefits. The plans are called coordinated care organizations or CCOs. UHA is a CCO. CCOs organize and pay for your health care. UHA serves most of Douglas County, with the exception of some areas in Reedsport, Gardiner, Winchester Bay, and Scottsburg:

All CCOs offer the same OHP benefits. Some offer extra services like new baby items and gym memberships. Learn more about UHA benefits on page 34, and pages 38-60.

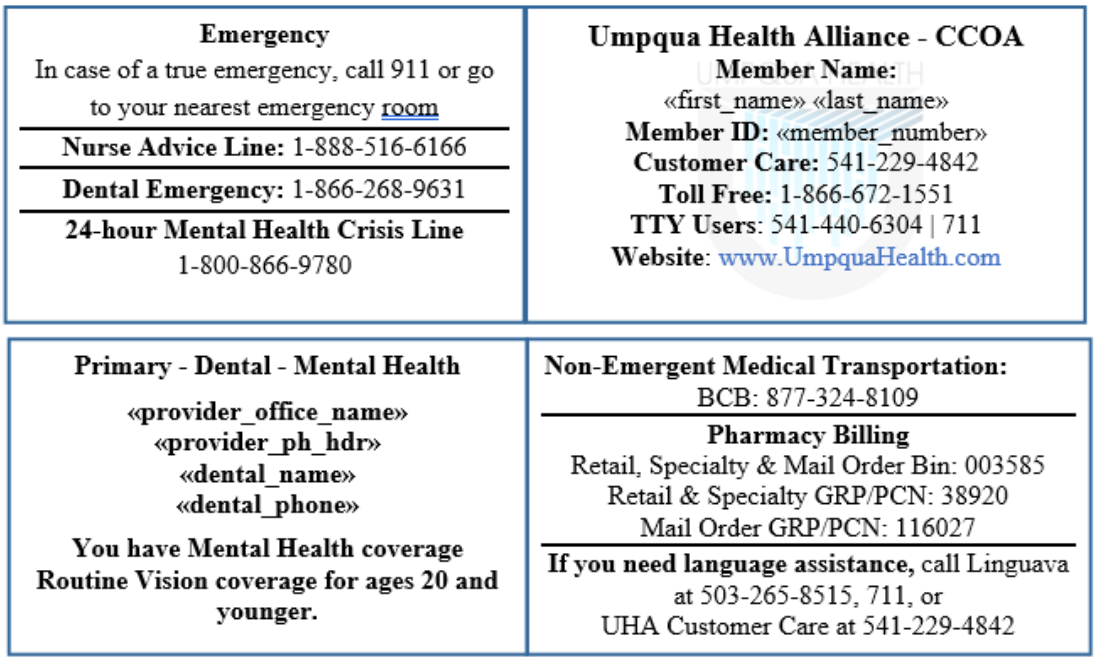
When you enroll in OHP, you will get an Oregon Health ID card. This is mailed to you with your coverage letter. Each OHP member in your household gets an ID card.

Your Oregon Health ID Card will look like this:



When you enroll in a CCO, you will also get a CCO ID card. This card is very important. It shows that you are a(n) UHA member and lists other information like important phone numbers. Your primary care provider (PCP) will also be listed on your ID card.

Your UHA ID card will look like this:



Emergency	Umpqua Health Alliance - CCOA
In case of a true emergency, call 911 or go to your nearest emergency room	**Member Name:** «first_name» «last_name»
Nurse Advice Line: 1-888-516-6166	**Member ID:** «member_number»
Dental Emergency: 1-866-268-9631	**Customer Care:** 541-229-4842
24-hour Mental Health Crisis Line 1-800-866-9780	**Toll Free:** 1-866-672-1551
	TTY Users: 541-440-6304 | 711
	Website: www.UmpquaHealth.com

Primary - Dental - Mental Health	Non-Emergent Medical Transportation:
«provider_office_name» «provider_ph_hdr» «dental_name» «dental_phone»	BCB: 877-324-8109
You have Mental Health coverage Routine Vision coverage for ages 20 and younger.	**Pharmacy Billing** Retail, Specialty & Mail Order Bin: 003585 Retail & Specialty GRP/PCN: 38920 Mail Order GRP/PCN: 116027
	If you need language assistance, call Linguava at 503-265-8515, 711, or UHA Customer Care at 541-229-4842

Be sure to show your UHA ID card each time you go to an appointment or the pharmacy.

Your coverage letter and UHA ID card will tell you what CCO you are enrolled in. They will also tell you what level of care your plan covers:

- CCOA: Medical, dental, and behavioral health
- CCOB: Medical and behavioral health
- CCOE: Behavioral health only
- CCOG: Dental and behavioral health
- CCOF: Dental only

Contact us

The UHA office is open Monday through Friday, from 8:00 a.m. to 5:00 p.m.

We're closed on the following holidays:

- New Year's Day (01/01/24)
- Memorial Day (05/27/24)
- Independence Day (07/04/24)
- Labor Day (09/02/24)
- Veteran's Day (11/11/24)
- Thanksgiving (11/28/24)
- Friday after Thanksgiving (11/29/24)
- Christmas (12/25/24)

Phone number: 541-229-4842, TTY 541-440-6304 or TTY 711, Toll-free: 866-672-1551. We can help you with language access.
Email: UHCustomerCare@umpquahealth.com
Website: www.umpquahealth.com

Our office location and mailing address is:

Umpqua Health Alliance
3031 NE Stephens St
Roseburg, OR 97470

If you would like to meet face-to-face with one of our Customer Care representatives, you can schedule a Zoom meeting with us. You can ask us about your coverage or any questions you have about your health plan. If you would like to schedule a meeting, please contact UHA Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711. Or you can go to our website: www.umpquahealth.com/uha-customer-care/ and click the "Schedule a Zoom with Customer Care" button.

Important phone numbers

Medical and pharmacy benefits:

Call Customer Care: 541-229-4842, TTY 541-440-6304 or TTY 711.
Hours: Monday through Friday, 8:00 a.m. to 5:00 p.m.
Learn about medical benefits and care on page 34 and pages 38-48.

Dental benefits and care

Call Advantage Dental Services: 866-268-9631. TTY users, please call 711.
Hours: Monday through Thursday, 8:00 a.m. to 6:00 p.m. and Fridays 8:00 a.m. to 5:00 p.m.
Learn about dental benefits on pages 54-60.

Advantage Dental's call center is closed on the following holidays:

- New Year's Day (01/01/24)
- President's Day (02/19/2024)
- Memorial Day (05/27/24)
- Independence Day (07/04/24)
- Labor Day (09/02/24)
- Thanksgiving (11/28/24)
- Friday after Thanksgiving (11/29/2024)
- Christmas Day (12/25/24)

Free rides to physical care, dental care, or behavioral health care

You can get a free ride to physical care, dental care, and behavioral health visits. Call Bay Cities Brokerage (BCB) at 877-324-8109 to set up a ride. TTY users, please call 711.
Hours: Monday through Friday, 8:00 a.m. to 5:00 p.m. See the rides to care section on pages 75-79.

BCB's call center is closed on the following holidays:

- New Year's Day (01/01/24)
- Memorial Day (05/27/24)
- Independence Day (07/04/24)
- Labor Day (09/02/24)
- Veteran's Day (11/11/24)
- Thanksgiving (11/28/24)
- Christmas Day (12/25/24)

Behavioral health, drug, alcohol dependency, or substance use disorder treatment benefits and care:

Call Adapt Integrated Health Care: 24-hour crisis line: 1-800-866-9780
Youth & families: 541-229-8934. Adults: 541-440-3532.
Hours: Monday through Friday, 8:00 a.m. to 5:00 p.m.
Learn about behavioral health benefits and care on pages 48-53.

24/7 Nurse Advice Line (also called FoneMed)

This service is for current Umpqua Health Alliance members only. You can speak with trained nurses at any time to speak about symptoms you may be having. They will help you with you next steps in care. This is not for emergencies. If you have an emergency, call 911.
Call: 888-516-6166
Hours: 24 hours a day, 7 days a week

Contact the Oregon Health Plan

OHP Customer Service can help you:

- Change your address, phone number, family status or other information.
- Replace a lost Oregon Health ID card.
- Apply or renew benefits.
- Get local help from a community partner.

How to contact OHP Customer Service.

- Phone: Toll-free 800-699-9075 (TTY 711)
- Website: www.OHP.Oregon.gov
- Email: Use the secure email site at secureemail.dhsoha.state.or.us/encrypt to send your email to Oregon.Benefits@odhsoha.oregon.gov.
    - Tell us your full name, date of birth, Oregon Health ID number, address, and phone number.

Your Rights and Responsibilities

{OAR 410-141-3590, OAR 410-141-3585, and 42 CFR 438.100 and 42 CFR through 438.210}

As a member of UHA you have rights. There are also responsibilities or things you have to do when you get OHP. If you have any questions about your rights and responsibilities or need them in an alternative format like video or audio, call Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711. You can read our Member Rights policy at www.umpquahealth.com/services/#notices-policies. You can also request a written copy be mailed at no cost to you.

You have the right to exercise your member rights without a bad response or discrimination. You can make a complaint if you feel like your rights have not been respected. Learn more about making complaints on pages 101-102. You can also call an Oregon Health Authority Ombudsperson at 877-642-0450 (TTY 711). You can send them a secure email at www.oregon.gov/oha/ERD/Pages/Ombuds-Program.aspx.

There are times when people under age 18 (minors) may want or need to get health care services on their own. To learn more, read “Minor Rights: Access and Consent to Health Care.” This booklet tells you the types of services minors can get on their own and how their health records may be shared.

You can read it at www.OHP.Oregon.gov and click on “Minor rights and access to care.” Or go to: sharedsystems.dhsoha.state.or.us/DHSForms/Served/le9541.pdf.

Your rights as an OHP member.

Access

- To have access to covered services during the same office hours as everyone else.
- Get emergency and urgent care when you need it without a prior authorization. Any time of day or night, including weekends and holidays.
- To have needed and reasonable services to diagnose the current problem.
- To choose a diverse provider, if available within the network, in any settings. One that is also easy for families to access.
- To be treated by in-network providers with the same dignity and respect as other people who get care, not on OHP.
- Get information about all of your covered and non-covered care options. This is to allow you to make informed choices about your care.
- To get community-based care that is as close to where you live as possible. This includes oversight, care coordination, transition and discharge planning by UHA. This is in hopes of keeping you out of the hospital.
- Get help with addiction to cigarettes, covered mental health, substance use disorder treatment, family planning, or related services without a referral.
- Get a referral to a specialist for covered services.
- To get a referral or a second opinion at no cost to you, with UHA’s policies followed.
- To receive care at places that offer equal access to males and females under the age of 18. This includes services and care available through human services and the juvenile corrections program provided by or funded by the State of Oregon (ORS 417.270).
- To have direct access to a women’s health specialist for females.
- Be made aware of your rights under Title VI if the Civil Rights Act and ORS Chapter 659A.

Care

- To choose a Primary Care Provider (PCP) and be able to change your provider as allowed by UHA’s policies.
- To get notice of canceled appointments in a timely manner.
- Help make decisions about your health care. This includes refusing care, except when court ordered.
- To have one source of person-centered care and services that give you choices, independence, dignity, and that meet the standards of medical care and fitting to your medical needs.
- To have regular contact with a care team. They are responsible for managing your care.
- To help get health care, local and social support services, and statewide services. Your care team may include: the use of certified or qualified health care interpreters, and certified traditional health workers. These include community health workers, peer wellness specialists, peer support specialists, doulas, and personal health navigators. This is to provide cultural and language help in making decisions about your care and services.
- Actively help make a treatment plan. To have your family involved. To talk openly with your provider about treatment choices that are medically necessary for your conditions, no matter the cost or benefit coverage.
- To have a clinical record that notes conditions, services you got, and referrals made.

- To execute a statement of wishes for treatment like an Advance Directive. This includes the right to accept or refuse medical, surgical, or behavioral health treatment and the right to execute directives and powers of attorney for health care established under ORS 127.
- To execute a Declaration of Mental Health Treatment in accordance with ORS 127.703, and to file a complaint if a Declaration of Mental Health Treatment is not followed.
- To get covered preventative services.
- To get needed covered services.
    - If UHA's provider network is unable to provide these services, UHA will, in a timely manner, cover services to an out of network provider until our network can provide them.

Support

- To get services and supports that fit your cultural and language needs and provided in your community. This means in a way that respects your culture. Including the use of auxiliary aids. This is to help those with disabilities get access to health information as required by law (Section 1557 of the PPACA).
- To have providers that make sure you will have physical access, reasonable accommodations, and accessible equipment.
    - To get these services, please let your provider know what your needs are.
- To get written materials that tell you about your:
    - Rights and responsibilities
    - Benefits available
    - How to access services
- What to do in an emergency.
- Have a friend or helper come to your appointments and other times as allowed by clinical rules.
- To have written materials explained in a way that you understand. This includes how coordinated care works and how to get services in the coordinated health care system.
- To get free certified or qualified health care interpreter services, and to have information given to you in a way that works for you. For example, you can get information in other languages, in Braille, in large print, or other formats such as electronic, audio, or video.
- To have care coordination and transition planning from UHA in a language you understand and in a way that respects your culture.
- To get information according to the law (42CFR438.10) within 30 days after your enrollment and within the timeframe Medicare requires for FBDE members. You have the right to get this information at least once a year.
- UHA will make sure staff who have contact with potential members are fully trained on plan policies. The training will include the policies on Enrollment, Disenrollment, Fraud, Waste and Abuse, Grievances and Appeals, and Advance Directives. Also including the Certified and Qualified Health Care Interpreter services available and the in-network medical practices and facilities who have bilingual providers or staff.

Nondiscrimination

- To be treated with dignity and respect.
- To be free from any form of restraint or seclusion.
- To freely exercise your rights. The exercising of those rights will not change the way UHA, our network providers, or the State Medicaid agency treats you.

- Know how to make complaints and get a response without a bad reaction from the plan or provider.
- Complain about different treatment and discrimination.
- The ability to make a report if you believe your rights are being denied, your health information isn't being protected, or you feel that you have been discriminated against. You may do one or more of the following:
    - File a complaint with UHA, the Client Services Unit for the Oregon Health Plan, the Bureau of Labor and Industries, or the Office of Civil Rights. See pages 11-12 for more information about filing a report.
    - Get written notice of UHA's nondiscrimination policy and process
    - Ask for and get information on the structure and operation of UHA or any physician incentive plan
- To request a hearing.
- To get information and help to appeal denials and ask for a hearing.
- Get a Notice of Adverse Benefit Determination (NOABD) letter if you are denied a service or there is a change in service level.
- To know that your medical record is confidential, with exceptions determined by law. To get a notice that tells you how your health information may be used and shared. With the right to decide if you want to give permission before your health information can be used or shared for certain purposes.
- To transfer, or have UHA transfer, a copy of your clinical record to another provider.
- To have access to your own clinical record unless restricted by law. To get a copy, and have corrections made to your health record.
- To exercise all rights, even if the member is a child, as defined by OARs. There are times when people under age 18 may want or need to get health care services on their own. To learn more about the rights of a minor, please go here: sharedsystems.dhsoha.state.or.us/DHSForms/Served/le9541.pdf.

Your responsibilities as an OHP member

Getting Care

- Find a doctor or other provider you can work with. Tell them all about your health.
- Help the provider or clinic get clinical records from other providers. This may include signing a Release of Information.
- Give accurate information to your provider for your medical records.
- Help make a treatment plan with your provider and follow the agreed upon plan. Be actively engaged in your health care.
- Use information provided by UHA's providers or care teams to make informed decisions about care before it is given.
- Follow your providers and pharmacist's directions. Ask questions about conditions, treatments, and other issues related to care that you do not understand.
- Call your provider at least one day before if you can't make it to an appointment.

Things You May Have to Pay for

- To pay for services not covered by OHP described in OAR 410-120-1200 (Excluded Services and Limitations) and 410-120-1280 (Billing).
- To pay your monthly OHP premium on time if you have one.

- To help UHA find any third-party coverage you have. Pay UHA back for benefits we paid, for an injury or any recovery you may have gotten due to that injury.

What to Do Next

- Have yearly check-ups, wellness visits, and other services to prevent illness and keep you healthy.
- Be on time for appointments. Call ahead of time to cancel if you can't keep the appointment or if you think you'll be late.
- Bring your Medical ID Cards to appointments. Tell the receptionist or provider that you have UHA/OHP or any other health insurance before you receive services. Tell them if you were hurt in an accident.
- Treat providers, their staff, and UHA with the same respect you want.
- Obtain a referral to a specialist from the PCP or clinic before seeking care from a specialist (unless self-referral to the specialist is allowed).
- Proper use of urgent and emergency services. As well as notify your PCP or clinic within 72 hours of using emergency services.
- Use your PCP or clinic for all your non-emergent medical care. Only use the ER for emergencies.
- Call OHP Customer Services at 1-800-699-9075 (TTY 711) if you are pregnant or no longer pregnant. Also tell them when your child is born.
- Call OHP Customer Services at 1-800-699-9075 (TTY 711) or tell your Authority worker of a change in address or phone number. Also tell them if any family member moves in or out of the household.
- To bring issues, complaints, or grievances to the attention of UHA.
- Tell the Department or Authority worker if you have any other insurance coverage.

American Indian and Alaska Native Members

American Indians and Alaska Natives have a right to choose where they get care. They can use primary care providers and other providers that are not part of our CCO, like:

- Tribal wellness centers.
- Indian Health Services (IHS) clinics. Find a clinic at www.ihs.gov/findhealthcare/.
- Native American Rehabilitation Association of the Northwest (NARA). Learn more or find a clinic at www.naranorthwest.org

You can use other clinics that are not in our network. Learn more about referrals and preapprovals on pages 35-37.

UHA is contracted with Cow Creek Health and Wellness, who has two locations:

Roseburg:

- Address: 2859 NW Edenbower Blvd.
  Roseburg OR, 97471
- Phone: 541-672-8533, toll-free: 1-800-929-8229
- Website: www.cowcreek-nsn.gov
- Email: info-wellness@cowcreek-nsn.gov

Canyonville:

- Address: 480 Wartahoo Lane
  Canyonville, OR 97417
- Phone 541-672-8533, toll-free: 1-800-929-8229
- Website: www.cowcreek-nsn.gov
- Email: info-wellness@cowcreek-nsn.gov

American Indian and Alaska Natives don't need a referral or permission to get care from these providers. These providers must bill UHA. We will only pay for covered benefits. If a service needs approval, the provider must request it first.

American Indian and Alaska Natives have the right to leave UHA any time and have OHP Fee-For-Service (FFS) pay for their care. Learn more about leaving or changing your CCO on pages 93-96.

New members who need services right away

Members who are new to OHP or UHA may need prescriptions, supplies, and other items or services as soon as possible. If you can't see your primary care provider (PCP) or primary care dentist (PCD) in your first 30 days with UHA:

- Call Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711 and ask for Care Coordination. They can help you get the care you need. Care Coordination can help OHP members with Medicare, too. See pages 29-34 for Care Coordination.
- Make an appointment with your PCP as soon as you can. You can find their name and number on your UHA ID card.
- Call Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711 if you have questions and want to learn about your benefits. They can help you with what you need.

Primary care providers (PCPs)

A primary care provider is who you will see for regular visits, prescriptions, and care. You can pick one, or we can help you pick one.

Primary care providers (PCPs) can be doctors, nurse practitioners and more. You have a right to choose a PCP within the UHA network. If you do not pick a provider within 90 days of becoming a member, UHA will assign you to a clinic or pick a PCP for you. UHA will notify your PCP of the assignment and send you a letter with your provider's information.

If at any time you want to change your PCP, call UHA Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711. The change is effective the same day.

If you would like a copy of our PCP Assignment Policy, including information on changing PCPs, please call Customer Care. We will mail you a copy, free of charge, within 5 business days.

There is a limit to your freedom of choice of our in-network PCPs. Some PCPs are not accepting new patients. UHA is also unable to assign to PCPs that are not in our coverage area.

Your PCP will work with you to help you stay as healthy as possible. They keep track of all your basic and specialty care needs. Your PCP will:

- Get to know you and your medical history.
- Provide your medical care.
- Keep your medical records up-to-date and in one place.

Your PCP will refer you to a specialist or admit you to a hospital if needed.

Each member of your family on OHP must pick a PCP. Each person can have a different PCP.

Don't forget to ask UHA about a dentist, mental health provider, and pharmacy.

Mental health services are covered to all OHP members. UHA does not assign you to a Mental Health provider. You do not need a referral to get mental health service from an in-network provider. For more information about mental health services, see pages 48-53.

Each member of your family must have a dentist that will be their primary care dentist (PCD). You will go to your PCD for most of your dental care needs. Your PCD will send you to a specialist if you need to go to one. Advantage Dental Services will assign you a PCD, or you can pick one.

Your PCD is important because they:

- Are your first contact when you need dental care.
- Manage your dental health services and treatments.
- Arrange your specialty care.

Please call Advantage Dental Services at 866-268-9631 (TTY 711) Monday through Thursday, 8:00 a.m. to 6:00 p.m. and Fridays 8:00 a.m. to 5:00 p.m. if you would like to change your PCD.

You may choose to fill your medications at any of our contracted pharmacies. For a list of in-network retail and mail-order pharmacies, visit the Provider Directory at www.portal.umpquahealth.com/ClientApp/pharmacies.

In-network providers

UHA works with some providers, but not all of them. Providers that we work with are called in-network or participating providers. Providers we do not work with are called out-of-network providers. You may be able to see out-of-network providers if needed, but they must work with the Oregon Health Plan.

You may be able to see an out-of-network provider for primary care if:

- You are switching CCOs or move from OHP fee-for-service to a CCO (see pages 93-96)
- You are American Indian or Alaskan Native (see pages 25-26 and 94)

Provider directory

You can choose your PCP, PCD or other providers from the Provider Directory at: www.portal.umpquahealth.com/ClientApp/facilities. You can also call Customer Care for help finding a provider.

Here are examples of information you can find in the Provider Directory:

- If a provider is taking new patients.
- Provider type (medical, dental, behavioral health, pharmacy, etc.).
- How to contact them.
- Video and phone care (telehealth) options.
- Language help (including translations and interpreters).
- Accommodations for people with physical disabilities.

You can get a paper copy of the Provider Directory. You can get it in the format you need (such as other languages, large print, or Braille). Call Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711 to request a copy free of charge. We will send it to you within 5 business days.

Make an appointment

You can make an appointment with your provider as soon as you pick one.

Your PCP should be your first call when you need care. They will make an appointment or help you decide what kind of care you need. Your PCP can also refer you to other covered services or resources. Call them directly to make an appointment.

If you are new to your PCP, make an appointment for a check-up. This way they can learn about you and your medical history before you have an issue or concern. This will help you avoid any delays the first time you need to use your benefits.

Before your appointment, write down:

- Questions you have for your PCP or other providers.
- History of family health problems.
- Prescriptions, over-the-counter medications, vitamins or supplements you take.

Call for an appointment during office hours and tell them:

- You are a UHA member.
- Your name and UHA ID number.
- What kind of appointment you need.
- If you need an interpreter and the language you need.

Let them know if you are sick and need to see someone that day.

You can get a free ride to your appointment. Learn more about free rides to care on pages 75-79.

Missed appointments

Try not to miss appointments. If you need to miss one, call your PCP and cancel right away. They will set up another visit for you. If you don't tell your provider's office ahead of time, they may not agree to see you again.

Each provider has their own rules about missed appointments. Ask them about their rules.

Changing your PCP

You can change your PCP at any time. If at any time you want to change your PCP, call UHA Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711. The change is effective the same day. You may also email us requesting to change at UHCustomerCare@umpquahealth.com.

Changes to UHA providers

We will tell you when one of your regular providers stops working with UHA. You will get a letter 30 days before the change happens. If this change was already made, we will send you a letter within 15 days after the change.

Second opinions

You have a right to get a second opinion about your condition or treatment. Second opinions are free. If you want a second opinion, call your doctor that referred you and tell them you want to see a different provider. For more information about services that need a referral, see pages 35-37.

If there is not a qualified provider within our network and you want to see a provider outside our network for your second opinion, contact UHA Customer Care and ask for Care Coordination. We will arrange the second opinion for free.

Survey about your health

Shortly after you enroll, UHA will mail you a survey about your health. You can complete the survey by mailing it in or completing it over the phone. You can also view the survey online:

- Phone: 541-229-4842, TTY 541-440-6304 or TTY 711
- Website: www.umpquahealth.com/case-management/
- Mail: UHA Customer Care
  3031 NE Stephens St.
  Roseburg, OR 97470

The survey about your health has questions about your general health with the goal of helping reduce health risks, maintain health, and prevent disease. If you would like to speak to a Care Coordinator or complete your health assessment over the phone, please call 541-229-4842, TTY 541-440-6304 or TTY 711, 8 a.m. to 5 p.m., Monday through Friday and ask for Care Coordination.

The survey asks about:

- Your access to food and housing.
- Your habits (like exercise, eating habits, and if you smoke or drink alcohol).
- How you are feeling (to see if you have depression or need a mental health provider).
- Your general well-being, oral health, and medical history.
- Your primary language.
- Any special health care needs, e.g., high risk pregnancy, chronic conditions, behavioral health disorders, and disabilities, etc.
- If you want support from a care coordination team.

Your answers help us find out:

- If you need any health exams, including eye or dental exams.
- If you have routine or special health care needs.
- Your chronic conditions.
- If you need long-term care services and supports
- Safety concerns.
- Difficulties you may have with getting care.
- If you need extra help with care coordination. See pages 29-34 for Care Coordination.

A Care Coordination team member will look at your survey. They will call you to talk about your needs and help you understand your benefits.

If we do not get your survey, a Care Coordinator will attempt to reach you by phone or text message. UHA will make three attempts to complete this survey within 90 days of enrollment, or sooner for members who have special health care needs. You will get another survey annually or if there is a change in your health status. If you want us to send you a survey, you can call UHA Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711 and we will send you one.

Your survey may be shared with your doctor or other providers. UHA will ask for your permission before sharing your survey with providers. By sharing your answers, we can work closer with your healthcare team to give you better whole-person service and care.

Get help organizing your care with Care Coordination

Care Coordination is the organized coordination of a member's health care services, support activities, and resources. Care Coordination occurs between, and among, two or more participants

deemed responsible for the member's health outcomes. You get Care Coordination from places like your patient-centered primary care home (PCPCH), primary care provider, UHA, or other primary care teams. You can visit www.umpquahealth.com/case-management/ for more information about Care Coordination.

UHA has staff that are part of your Care Coordination team. UHA staff are committed to supporting members with their care needs and can assist you with finding physical, developmental, dental, behavioral, and social needs where and when you need it. The purpose of Care Coordination is to help you get the best care for your needs. They will work together to help find out your health care needs and help you take charge of your health and wellness. They will connect you with community and social support resources that may help you.

Your Care Coordination team will:

- Help you understand your benefits and how they work.
- Help you pick a primary care provider.
- Provide care and advice that is easy to follow.
- Help with setting up medical appointments and tests.
- Help you set up transportation to your medical appointments.
- Help you get care from specialty providers.
- Help make sure your providers talk to each other about your health care needs.
- Assist with changing to different care when needed.
- Access resources to make sure you feel comfortable, safe, and cared for.
- Help you manage chronic health conditions.
- Help with medical issues such as diabetes, heart disease and asthma.
- Help with behavioral health issues including depression and substance use disorder.
- Create a care plan with you that meets your health needs.

Your Care Coordination team can help you find and access other resources in your community, like help for non-medical needs. Some examples are:

- Help with finding housing.
- Help with rent and utilities.
- Nutrition services.
- Rides.
- Trainings and classes.
- Family support.
- Social services.
- Devices for extreme weather conditions.

Your Care Coordination team will work closely with you and your provider to manage and organize your services. Your care team will include different people who will work together to meet your needs, such as providers, specialists and community programs you work with. We want to make sure anyone who gives you care can focus on helping you stay well and improving your health. Care Coordination will help you create a care plan to make sure you get the best treatment. They will also check in with you after your care to see how things are going.

Your care plan will list supports and services needed to help you reach your goals. This plan addresses medical, dental, cultural, developmental, behavioral, and social needs so you have positive health and wellness results. The plan will be reviewed and updated at least annually and as your needs change or if you ask for it. You will get a copy of your care plan at no cost to you.

The nurses and case managers on a Care Coordination team have special training in many health conditions. They can help you with:

- Diabetes.
- Heart failure.
- Asthma.
- Depression.
- High blood pressure.
- And other conditions.

Care Coordination Availability

Care Coordination services are available Monday through Friday 8:00 a.m. to 5:00 p.m. If you can't get Care Coordination services during normal business hours, UHA will give you other options.

- Call UHA Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711 to get more information about Care Coordination.
- When you are enrolled in Care Coordination, UHA will give you or your representative the name and phone number of who, from your Care Coordination team, is primarily responsible for coordinating your care.
    - If your Care Coordinator changes, UHA will send you a letter with information how to contact your new Care Coordinator. You may also receive a call from them.

Members with Medicare

You can also get help with your OHP and Medicare benefits. A staff member from the UHA care coordination team works with you, your providers, your Medicare Advantage plan and/or your caregiver. We partner with these people to get you social and support services, like culturally specific community-based services.

Members who are pregnant

If you are pregnant, OHP provides extra services to help keep you and your baby healthy. UHA can help you get the care you need. You can also be covered for your delivery and for your care for one year after your pregnancy.

Here's what you need to do before you deliver:

- **Tell OHP that you're pregnant as soon as you know.** Call 800-699-9075 (TTY 711) or login to your online account at ONE.Oregon.gov.
- **Tell OHP your due date.** You do not have to know the exact date right now. If you are ready to deliver, call us right away.
- **Ask us about your pregnancy benefits.** UHA offers case management for pregnant women. There are two programs to help, maternity case management and New Day. After the baby is born, UHA also has a program called New Beginnings program for children birth to age five. For more information about these programs, see pages 32-34.

After you deliver:

- **Call OHP or ask the hospital to send a newborn notification to OHP.** OHP will cover your baby from birth. Your baby will also have UHA.
- **Get a free nurse home visit through Healthy Families with United Community Action Network (UCAN).** It is a nurse home visiting program that is free for members who are pregnant or for members that just delivered.
    - For more information, call UCAN at 800-301-8226 or fill out their online program referral form here: www.ucancap.org/referral/.

Maternity Case Management

Maternity Case Management is a service of Umpqua Health Alliance for moms in Douglas County on the Oregon Health Plan. They work together with you, your OB doctor and other community providers and agencies to offer support and resources.

Maternity Case Management can help with:

- Evaluating your needs
- Connection with an OB/GYN
- Making and keeping your appointments
- Transportation
- Connection to resources
- Additional support

Are you pregnant and unsure what to do next? Most importantly, see a doctor. You can:

- Call your PCP and get a referral.
- Call your OB/GYN to make an appointment.
- Call Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711 and ask for help.
- Ask your counselor, case manager, or any community partner for help.
- Call to make a self-referral.

Referrals for Maternity Case Management can be sent to UHA Case Management by phone, email or fax.

- Office: 541-229-4842, TTY 541-440-6304 or TTY 711
- Email: CaseManagement@umpquahealth.com
- Fax: 541-229-8180

New Day Program

New Day is a service of Umpqua Health Alliance for moms in Douglas County on the Oregon Health Plan. They help pregnant women struggling with substance abuse or other challenges. They work together with you, your OB doctor, and other community providers and agencies to offer support and resources.

The New Day staff can help with:

- Evaluating your needs
- Emotional support
- Counseling
- Buprenorphine Medication Assisted Therapy (MAT)
- Methadone/Suboxone plan
- Drug treatment options
- Stop smoking
- Making and keeping your appointments
- Finding resources

Substance Use During Pregnancy: A lot of things can cause problems for babies before and after they are born. Sometimes those problems last a lifetime. Smoking, alcohol, substance abuse,

marijuana, unsafe housing, poor nutrition, domestic violence, and stress are harmful to pregnant women and their children. The New Day program can help you deal with these things. Even small changes can make a BIG difference.

If you are currently using opiates like heroin or pain pills, or in a methadone or Suboxone program, they can work with a doctor who specializes in MAT to help you get through your pregnancy safely. You want a healthy baby, and we want to help get you there.

Our Staff: The New Day program is led by Mandy Rigsby, BA, CCM, NCAC II, CADC II, CGAC I, IMH-E.

Referrals to New Day can be sent to UHA Care Coordination by phone, email, or fax. Arrangements can also be made for a meeting place in the community.

- Office: 541-229-4842, TTY 541-440-6304 or TTY 711
- Email: CaseManagement@umpquahealth.com
- Referral Fax: 541-229-8180

New Beginnings Program

New Beginnings is a program offered by Umpqua Health Alliance for Oregon Health Plan members in Douglas County. We focus on children birth to age five. We work with the child, family, care providers, and community partners to offer support and resources. The New Beginnings staff create and strengthen partnerships so you can use community resources. This includes:

- Counseling
- Primary care physicians
- Family development centers
- Child Advocates
- Abuse prevention services
- Early Intervention Specialists
- Schools and childcare services
- Hospitals
- Housing and food assistance programs
- Women, Infants and Children (WIC)
- Dentists
- Transportation needs

The Early Years: The first few years of a child's life are important for the physical and social development of that child. Children in poverty or who lack stable housing and healthy foods can have a hard time coping.

Every parent wants what is best for their child, and that's where New Beginnings can help. Together, through coordinated care, each child's unique needs will be identified and addressed. New Beginnings will also help parents create a solid foundation for Douglas County children to grow and thrive.

Do you have a young child? Most importantly, go to well child visits. You can also:

- Call your child's doctor to make an appointment
- Call UHA Customer Care at 541-229-4842 (TTY 711) or TTY 541-440-6304

- Ask your counselor, case manager or any community partner for help
- Call New Beginnings

Referrals to New Beginnings can be sent to UHA Care Coordination by phone, email, or fax.

- Office: 541-229-4842, TTY 541-440-6304 or TTY 711
- Email: CaseManagement@umpquahealth.com
- Fax: (541) 229-8180

Your benefits

How Oregon decides what OHP will cover

Many services are available to you as an OHP member. How Oregon decides what services to pay for is based on the **Prioritized List of Health Services**. This list is made up of different medical conditions (called diagnoses) and the types of procedures that treat the conditions. A group of medical experts and ordinary citizens work together to develop the list. This group is called the Oregon Health Evidence Review Commission (HERC). They are appointed by the governor.

The list has combinations of all the conditions and their treatments. These are called condition/treatment pairs. The condition/treatment pairs are ranked on the list by how serious each condition is and how effective each treatment is.

For members aged 21 and older:
Not all condition and treatment pairs are covered by OHP. There is a stopping point on the list called "the line" or "the funding level." Pairs above the line are covered, and pairs below the line are not. Some conditions and treatments above the line have certain rules and may not be covered.

For members birth to under age 21:
All medically necessary and medically appropriate services must be covered, based on your individual needs and medical history. This includes items "below the line" on the Prioritized List as well as services that don't appear on the Prioritized List, like Durable Medical Equipment. See pages 67-70 for more information on coverage for members birth to under age 21.

Learn more about the Prioritized List at:
www.oregon.gov/oha/hsd/ohp/pages/prioritized-list.aspx.

Direct Access

You have "direct access" to providers when you do not need a referral or preapproval for a service. You always have direct access to emergency and urgent services.

No referral or preapproval needed

- Emergency services
  - For physical, dental, or behavioral health
- Urgent Care services
  - For physical, dental, or behavioral health
- Family Planning services
- Women's Health services
  - For routine and preventive care, in addition to services received from your PCP
- Sexual Abuse Exams
- Care Coordination services
  - Available for all members
- Peer Delivered services
- Physical or behavioral health specialists for members with special health care needs (SHCN) who are receiving long term support services (LTSS)

Getting preapproval

Some services need approval before you get the service. This is known as a "prior authorization (PA)" or "preapproval". Your provider works with UHA to ask for preapproval for a service. Sometimes your provider may submit information to us to support you getting the service. Even if the provider is not required to send us information, UHA may still need to review your case to make sure that you should receive the service.

These decisions are based only on whether the care or service is right for you and if you are covered by UHA. UHA does not reward providers or any other persons for issuing denials of coverage or care. Extra money is never give to anyone who makes a decision to say no to a request for care. Contact UHA Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711 if you:

- Have questions
- Need to reach our Utilization Management Department
- Need a copy of the clinical guidelines

You might not get the service if it is not approved. We review preapproval requests as quickly as your health condition requires. Most service decisions are made within 14 days. Sometimes a decision may take up to 28 days. This only happens when we are waiting for more information. If you or your provider feel following the standard time frame puts your life, health or ability to function in danger, we can make an "expedited service authorization" decision. Expedited service decisions are typically made within 72 hours, but there may be a 14-day extension. You have the right to complain if you don't agree with an extension decision. See pages 100-102 for how to file a complaint.

How do I get a prior authorization (PA)?

Your provider will submit a PA to us. In-network providers must submit a PA through our provider portal. If the provider is out-of-network, they can fax the request on our PA Form with medical notes to support the need for the service. This form is available on our website at www.umpquahealth.com/prior_authorizations/. The provider can call us if they need help getting one. UHA's PA/Referral Policies are on our website at www.umpquahealth.com/provider-trainings/.

You can also contact UHA Customer Care at 541-229-4842. We can mail you a copy, free of charge, within five business days.

An approved PA is not a guarantee of payment. Payment is based on benefits in effect at the time of service, member eligibility, and medical necessity.

How long does it take to get a PA?
UHA follows all state rules when making a decision on requests for services. Some services need to be reviewed quicker than others per the state rules. Below is how long it can take for some services to be authorized.

- Prescription drugs – 24 hours
- Substance Use Disorder (SUD) detoxification and residential treatment and skilled nursing facility – 2 business days
- Behavioral health inpatient and residential services and fast (expedited) requests (if waiting for the regular appeal could put your life, health, or ability to function in danger) – 72 hours
- Standard requests for all other services – 14 days

You do not need approval for emergency or urgent services or for emergency aftercare services. See pages 84-89 to learn about emergency services.

Services that do not need preapproval

- Behavioral Health Assessment and Evaluation services
- Outpatient and Peer-Delivered Behavioral Health services
  - From an in-network provider
- First 30 days of Medication Assisted Treatment for Substance Use Disorder
  - Referral is needed.
- Assertive Community Treatment (ACT) and Wraparound services
  - Must complete a screening

Services that need preapproval

- Inpatient Hospital Services
- Outpatient services in an Ambulatory Surgery Center or hospital setting
- Inpatient, Residential, and Detox services for Substance Use Disorder
- Some durable medical equipment (DME)
- Outpatient services from out-of-network providers
- Therapies (acupuncture, chiropractic, physical, speech, occupational)
- Medication Assisted Treatment for Substance Use Disorder after the first 30 days
- Out-of-network Substance Use Disorder services
- Partial or complete dentures
- Crowns
- Root canal therapy on molars

UHA may require preapproval for services that are not listed here. See our PA Grid on our website found here: www.umpquahealth.com/prior_authorizations.

Provider referrals and self-referrals

For you to get care from the right provider a referral might be needed. A **referral** is a written order from your provider noting the need for a service.

If your PCP cannot give you services you need, they can refer you to a specialist. If preapproval is needed for the service, your provider will ask UHA for approval. If there is not a specialist close to where you live or who works with UHA (also called in-network), they may have to work with the Care Coordination team to find you care out-of-network. There is no extra cost if this happens.

A lot of times your PCP can perform the services you need. If you think you might need a referral to a health care specialist, ask your PCP. If you have special health care needs, your health care team can work together to get you access to specialists without a referral. You do not need a referral if you are having an emergency.

Some services do not need a referral from your provider. This is called a self-referral.

A **self-referral** means you can look in the provider directory to find the type of provider you would like to see. You can call that provider to set up a visit without a referral from your provider. Learn more about the Provider Directory on page 27. **Preapproval may still be needed for a service when you use self-referral. Talk with your PCP or contact Customer Care if you have questions about if you need a preapproval to get a service.**

Services you can self-refer to:

- Visits with your PCP
- Care when you have an emergency
- Services from your OB/GYN in your network for routine or preventative services
- Care for sexually transmitted infections (STIs)
- Immunizations (shots)
- Traditional Health Worker (THW) services
- In-network vision providers
- In-network dental providers
- Covered family planning services from an out-of-network provider
- Behavioral health services from in-network providers
    - Includes inpatient or residential services
- Mental health services for problems with alcohol or other drugs
- Assertive Community Treatment (ACT)

Benefits charts icon key

		
Services that need preapproval Some services need approval before you get the service. Your provider must ask the CCO for approval. This is known as a preapproval.	**Services that need a referral** A referral is a written order from your provider noting the need for a service. You must ask a provider for a referral.	**No referral or preapproval needed** You do not need a referral or preapproval for some services. This is called direct access.

Physical health benefits

See below for a list of medical benefits that are available to you at no cost. Look at the “Service” column to see how many times you can get each service for free. Look At the “In-network services” and “Out-of-network services” columns to see if you need to get a referral or preapproval for the service. UHA will coordinate services for free if you need help. If you see an * in the benefit charts, this means a service may be covered beyond the limits listed for members under 21, if medically necessary and appropriate. Please see pages 67-70 to learn more.

Service	In-network services	Out-of-network services	Who can get it
Care Coordination services Care Coordination is a team of people that help you navigate the healthcare system. Examples include help scheduling appointments, communicating with your providers and care planning. There are no limits to the amount, duration, and scope of this benefit. See pages 29-34 for more information.	 No referral or preapproval	 No referral or preapproval	All members
Comfort Care & Hospice Services* Services for those who are terminally ill. Examples include pain management, 24/7 nursing care, and emotional and spiritual support. Members have direct access to these services. Approval for these services is based on OHP guidelines. Contact UHA for more information.	 Preapproval may be needed	 Preapproval may be needed	Members with medical coverage through UHA (CCOA and CCOB benefit type)

Service	In-network services	Out-of-network services	Who can get it
Diagnostic Services These services are used to help diagnose a condition and guide treatment. Some examples may include imaging (x-ray, MRI, CT scan) bloodwork, laboratory services, etc. There are no limits to the amount, duration, and scope of this benefit. Self-referral is allowed.	 Preapproval may be needed	 Preapproval may be needed	Members with medical coverage through UHA (CCOA and CCOB benefit type)
Durable Medical Equipment (DME)* Items that you might need at home to help with a medical condition or recovery. Some examples are: Medical supplies (including diabetic supplies), Medical appliances, prosthetics, and orthotics. Oxygen rentals are limited to 36 months.	 Preapproval may be needed	 Preapproval may be needed	Members with medical coverage through UHA (CCOA and CCOB benefit type)
Well-Child Care, Early & Periodic Screening, Diagnosis and Treatment (EPSDT) services* EPSDT services are specifically for screening and assessments of both physical and mental health development. Examples include immunizations, vision and hearing screenings and lead screenings. There are no limits to the amount, duration, and scope of this benefit. See pages 67-70 for more information.	 No referral. Preapproval may be needed.	 No referral. Preapproval may be needed.	Members ages 0-20 years old

Service	In-network services	Out-of-network services	Who can get it
Elective Surgeries/Procedures* These are treatments you and your provider decide to have, not things you have to have because of a life-threatening situation. Examples are knee replacements or cosmetic surgeries. Approval for these services is based on OHP guidelines. Contact UHA for more information.	 Preapproval needed	 Preapproval needed	Members with medical and dental coverage through UHA (CCOA, CCOB, CCOG and CCOF benefit type)
Emergency Medical Transportation* Transportation for people experiencing a medical emergency. Ambulance rides are covered for emergencies only. We cover ambulance rides within the United States. Members have direct access to these services.	 No referral or preapproval	 No referral or preapproval	All members
Emergency Services These are services that need immediate attention, such as a sudden injury or illness. For more information about these services, see pages 84-89. There are no limits to the amount, duration, and scope of this benefit. Members have direct access to these services. Self-referral is allowed. UHA covers emergency care within the United States.	 No referral or preapproval	 No referral or preapproval	All members

Service	In-network services	Out-of-network services	Who can get it
Family Planning Services This service helps people make choices about their reproductive goals and promotes health for pregnant people and children. Some examples are birth control and annual exams. There are no limits to the amount, duration, and scope of this benefit. Members have direct access to these services.	 No referral or preapproval	 No referral or preapproval	Members with medical coverage through UHA (CCOA and CCOB benefit type)
Gender Affirming Care These services support and affirm a person's gender identity. Examples are hormone therapy, surgery, or mental health support. There are no limits to the amount, duration, and scope of this benefit.	 No referral or preapproval	 No referral or preapproval	Members with medical coverage through UHA (CCOA and CCOB benefit type)
Hearing Services* These services provide support, tools, and solutions to help your ability to hear and communicate. Some examples are audiology and hearing aids. Approval is based on OHP guidelines. Contact UHA for more information. • Adults who meet criteria are limited to one hearing aid every five years (two may be authorized if certain criteria are met). Children who meet criteria are allowed two hearing aids every three years.	 Preapproval needed for all hearing aids	 Preapproval needed for all hearing aids	Members with medical coverage through UHA (CCOA and CCOB benefit type)

Service	In-network services	Out-of-network services	Who can get it
Immunizations and Travel Vaccines Travel vaccines are recommended or required before traveling to certain regions or countries. Some immunizations and vaccines needed for travel are covered by UHA. There are no limits to the amount, duration, and scope of this medical benefit. Members have direct access to these services. Self-referral is allowed. For services under the pharmacy benefit, please see service section: Pharmaceutical Services (Prescription Medication) (page 44). See pages 80-82 for more information.	 No referral or preapproval	 Preapproval may be needed	Members with medical coverage through UHA (CCOA and CCOB benefit type)
Inpatient Hospital Services* This could include an overnight stay in the hospital. Examples include skilled nursing facilities or acute physical rehabilitation. Approval is based on OHP guidelines. Contact UHA for more information.	 No preapproval needed for: • Acute Care Hospital • Long Term Acute Care  Preapproval needed for: • Acute Physical Rehabilitation • Skilled Nursing Facilities	 Preapproval needed.	Members with medical coverage through UHA (CCOA and CCOB benefit type)

Service	In-network services	Out-of-network services	Who can get it
Interpreter Services Interpreters are for members or potential members who need help communicating in their own language. These can be done via phone, tablet, or in person. For more information, see pages 3-5. There are no limits to the amount, duration, and scope of this benefit. Members have direct access to these services.	 No referral or preapproval	 No referral or preapproval	All members
Maternity Services These services help make sure you and your baby stay healthy and safe during pregnancy, childbirth, and after the baby is born. Some examples are checkups, immunizations, or annual screenings. There are no limits to the amount, duration, and scope of this benefit.	 No preapproval needed	 No preapproval needed	Pregnant members with medical coverage through UHA (CCOA and CCOB benefit type)
Rides to care. Also called Non-Emergent Medical Transportation (NEMT) Services* These are free rides to covered medical services. You may also be reimbursed if you or someone else drives you. Limited for VA and COFA members. See page 61 for more information.	 Preapproval may be needed	 Preapproval may be needed	All members

Service	In-network services	Out-of-network services	Who can get it
Outpatient Hospital Services* This is for people who receive care or hospital services and return home the same day. Some examples are chemo, radiation, and pain management. Approval is based on OHP guidelines. Contact UHA for more information.	Preapproval may be needed	Preapproval may be needed	Members with medical coverage through UHA (CCOA and CCOB benefit type)
Pharmaceutical Services (Prescription Medication)* Medicines are what your provider prescribes to you to help you get better when you are sick or if you have a medical condition. Most drugs have a 90-day supply option at a participating network pharmacy, except for specialty medications. See pages 80-82 for more information. **Prescription needed**	Preapproval may be needed	Preapproval may be needed	Members with medical coverage through UHA (CCOA and CCOB benefit type)
Physical Therapy, Occupational Therapy, Speech Therapy* These therapies help with physical or communication challenges. Services are limited to a combined 30 visits total per 12 months. Additional visits may be authorized if medically appropriate. These visits require preapproval. Contact UHA for more information. Children under age 21 may have additional visits authorized if medically appropriate. These visits require preapproval.*	No preapproval needed for: • Evaluations • Funded and paired conditions Preapproval needed for: • Non-covered conditions • More than 30 visits	No preapproval needed for: • Evaluations Preapproval needed for: • All therapy visits	Members with medical coverage through UHA (CCOA and CCOB benefit type)

Service	In-network services	Out-of-network services	Who can get it
Preventive services These services help you avoid getting sick. Some examples are: physical examinations, well-baby care, immunizations, women's health (mammogram, gynecological exam, etc.), screenings (cancer, etc.), diabetes prevention, nutritional counseling, tobacco cessation services, etc. There are no limits to the amount, duration, and scope of this benefit. Members have direct access to these services.	 No referral or preapproval	 No referral or preapproval	Members with medical coverage through UHA (CCOA and CCOB benefit type)
Primary Care Provider Visits These are medical check-ups with your regular provider. You may see your provider for annual check-ups, preventive counseling, and referrals to specialists. There are no limits to the amount, duration, and scope of this benefit. See pages 26-28 for more information.	 No referral or preapproval	 Preapproval needed	Members with medical coverage through UHA (CCOA and CCOB benefit type)
Sexual Abuse Exams These medical exams help support someone who may have been sexually abused or assaulted. Some things done during the exam are a physical exam, collection of evidence, and counseling and support services. There are no limits to the amount, duration, and scope of this benefit. Members have direct access to these services.	 No referral or preapproval	 No referral or preapproval	Members with medical coverage through UHA (CCOA and CCOB benefit type)

Service	In-network services	Out-of-network services	Who can get it
Specialist Services* These services support people with a range of rare or complex conditions. Types of specialists include cardiologists, dermatologists or gynecologists. Approval is based on OHP guidelines. Contact UHA for more information.	 Preapproval may be needed	 Preapproval needed	All members. For those with special health care needs receiving LTSS, no referral is required.
Surgical Procedures* This is when a provider uses special tools to fix a problem, remove something harmful, or replace a damaged body part. Examples include hip or knee replacements. Approval is based on OHP guidelines. Contact UHA for more information.	 Preapproval may be needed	 Preapproval needed	Members with medical coverage through UHA (CCOA and CCOB benefit type)
Telehealth Services* Video care or care over the phone instead of in a provider's office. Some examples are secure email, patient portals, online audio/video conferencing and e-visits. See pages 79-80 for more information. Approval is based on OHP guidelines. Contact UHA for more information.	 No referral or preapproval	 Preapproval needed	All members

Service	In-network services	Out-of-network services	Who can get it
Traditional Health Worker (THW) services These are people who work with your care team to help you get the care you need. Some examples are birth doulas, community health workers (CHW) and peer support specialists (PSS). See pages 70-71 for more information. Approval is based on OHP guidelines. Contact UHA for more information. Self-referral is allowed.	 No referral or preapproval	 No referral or preapproval	All members
Urgent Care Services Urgent care is when you can't reach your PCP about an urgent problem or they can't see you soon enough. Urgent problems are severe infection, sprains and strong pains. See pages 82-84 for more information. There are no limits to the amount, duration, and scope of this benefit. Members have direct access to these services. Self-referral is allowed.	 No referral or preapproval	 No referral or preapproval	Members with medical coverage through UHA (CCOA and CCOB benefit type)
Women's Health Services (in addition to PCP) for routine and preventive care These services provide medical care and support for the needs and care of women. Examples include mammograms and pap smears. There are no limits to the amount, duration, and scope of this benefit. Members have direct access to these services. Self-referral is allowed.	 No referral or preapproval	 No referral or preapproval	Members with medical coverage through UHA (CCOA and CCOB benefit type)

Service	In-network services	Out-of-network services	Who can get it
Vision Services* These services provide support, tools, and solutions to help your ability to see. Examples include eye exams and glasses. **Non-pregnant adults (21+) are covered for:** • Routine eye exams every 24 months • Medical eye exams when needed • Corrective lenses/accessories only for certain medical eye conditions **Members birth to under age 21*, pregnant adults, adults up to 12 months post-partum are covered for:** • Routine eye exams every 24 months and when needed* • Medical eye exams when needed* • Corrective lenses/accessories when needed* Examples of medical eye conditions are aphakia, keratoconus, or after cataract surgery.	 Preapproval may be needed	 Preapproval needed	Members ages 0-20 years old and pregnant members with medical coverage through UHA (CCOA and CCOB benefit type) As recommended for all others

The table is not a full list of services that need preapproval or referral. If you have questions, please call UHA Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711.

Behavioral health care benefits

Behavioral health means mental health and substance use treatment. Look at the “Service” column to see how many times you can get each service for free. See the table on the next page for a list of behavioral health benefits that are available to you at no cost. Look At the “In-network services” and “Out-of-network services” columns to see if you need to get a referral or preapproval for the service. It is your right to access behavioral health services when you need them. Let us know if you need support, UHA is here to help you access services. All UHA coordination services are free. If you see

an * in the benefit charts, this means a service may be covered beyond the limits listed for members under 21, if medically necessary and appropriate. Please see pages 67-70 to learn more.

Service	In-network services	Out-of-network services	Who can get it
Care Coordination services Care coordination is a team of people that help you navigate the healthcare system. Examples include help scheduling appointments, communicating with your providers and care planning. There are no limits to the amount, duration, and scope of this benefit. See pages 29-34 for more information.	 No referral or preapproval	 No referral or preapproval	All members
Outpatient behavioral health services **This includes mental health and substance use.** These behavioral health services happen in places like an office or hospital, but you don't stay overnight. There are no limits to the amount, duration, and scope of this benefit. Members have direct access to these services. Self-referral is allowed.  **Screening Needed**	 No referral or preapproval	 Preapproval needed	Members with medical and mental health coverage through UHA (CCOA, CCOB, CCOE and CCOG benefit type)

Service	In-network services	Out-of-network services	Who can get it
Peer Delivered behavioral health services **This includes mental health and substance use.** These services offer support and advice from people who have faced similar behavioral health issues. There are no limits to the amount, duration, and scope of this benefit. Members have direct access to these services.  **Screening Needed**	 No referral or preapproval	 Preapproval needed	Members with medical and mental health coverage through UHA (CCOA, CCOB, CCOE and CCOG benefit type)
Inpatient Substance Use Disorder Services (Residential and Detox)* These services provide treatment and support for people who are struggling with drug or alcohol addiction. Approval based on OHP guidelines. Contact UHA.  **Screening Needed**	 No preapproval needed	 Preapproval needed	Members with medical coverage through UHA (CCOA and CCOB benefit type)
Medication Assisted Treatment for Substance Use Disorder* These services combine medication, counseling and support for people who are struggling with drug or alcohol addiction. Approval based on OHP guidelines. No preapproval required for first thirty (30) days. Contact UHA.  **Screening Needed**	 No preapproval needed	 Preapproval needed after first thirty (30) days	Members with medical coverage through UHA (CCOA and CCOB benefit type)

Service	In-network services	Out-of-network services	Who can get it
Assertive Community Treatment This treatment is a team of experts who support and care for people with severe mental health challenges. They work to help people maintain independence. There are no limits to the amount, duration, and scope of this benefit. Members have direct access to these services. Self-referral is allowed. **Screening Needed**	No preapproval needed	Preapproval needed	Members with medical and mental health coverage through UHA (CCOA, CCOB, CCOE and CCOG benefit type)
Intensive In-Home Behavioral Health Treatment (IIBHT) IIBHT is for children and families who need more support and services than traditional outpatient services provide. There are no limits to the amount, duration, and scope of this benefit. Members have direct access to these services. Self-referral is allowed. **Screening Needed**	No preapproval needed	Preapproval needed	Members with medical and mental health coverage through UHA (CCOA, CCOB, CCOE and CCOG benefit type)
Neuropsychological Evaluations This type of evaluation can help understand how a person's brain functions. This information can be used to develop treatment plans for different brain-related conditions. There are no limits to the amount, duration, and scope of this benefit. Members have direct access to these services. Self-referral is allowed. **Screening Needed**	Preapproval needed	Preapproval needed	Members with medical and mental health coverage through UHA (CCOA, CCOB, CCOE and CCOG benefit type)

Service	In-network services	Out-of-network services	Who can get it
Psychological Evaluations This type of evaluation can help a mental health professional see if you are experiencing a mental health problem. It also helps them assess your mental health condition. There are no limits to the amount, duration, and scope of this benefit. Members have direct access to these services. Self-referral is allowed. Some providers may prefer referral. Contact UHA. **Screening Recommended**	No preapproval needed	Preapproval needed	Members with medical and mental health coverage through UHA (CCOA, CCOB, CCOE and CCOG benefit type)
Wraparound Services These services provide support for individuals and families who may be facing challenges related to mental health or special needs. Wraparound creates a team who will work together to create a plan to support your goals. There are no limits to the amount, duration, and scope of this benefit. Members have direct access to these services. Self-referral is allowed. **Screening Needed**	No preapproval needed	Preapproval needed	Children and Youth that meet medical criteria.

Service	In-network services	Out-of-network services	Who can get it
Applied Behavior Analysis This is a type of therapy that helps people learn new behaviors and improve social and communication skills. There are no limits to the amount, duration, and scope of this benefit. Members have direct access to these services. Self-referral is allowed. **Screening Needed**	Preapproval needed	Preapproval needed	Members with medical and mental health coverage through UHA (CCOA, CCOB, CCOE and CCOG benefit type)
Electroconvulsive Therapy (ECT) This treatment sends an electric current through a person's brain to help treat severe symptoms of some mental health problems. There are no limits to the amount, duration, and scope of this benefit. Members have direct access to these services. Self-referral is allowed. **Screening Needed**	Preapproval needed	Preapproval needed	Members with medical and mental health coverage through UHA (CCOA, CCOB, CCOE and CCOG benefit type)
Transcranial Magnetic Stimulation (TMS) This treatment uses magnetic pulses to stimulate certain areas of the brain. It can be used to treat depression and other mental health conditions. There are no limits to the amount, duration, and scope of this benefit. Members have direct access to these services. Self-referral is allowed. **Screening Needed**	Preapproval needed	Preapproval needed	Members with medical and mental health coverage through UHA (CCOA, CCOB, CCOE and CCOG benefit type)

The table is not a full list of services that need preapproval or referral. If you have questions, please call UHA Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711.

Dental benefits

All Oregon Health Plan members have dental coverage. OHP covers annual cleanings, x-rays, fillings, and other services that keep your teeth healthy.

Healthy teeth are important at any age. Here are some important facts about dental care:

- A healthy mouth can help prevent pain.
- Healthy teeth can keep your heart and body healthy, too.
- You should see your dentist once a year.
- When you're pregnant, keeping your teeth and gums healthy can protect your baby's health.
- Regular dental cleanings can help you control your blood sugar.
- Children should have their first dental check-up by age 1.
- Infection in your mouth can spread to your heart, brain, and body.

Your primary care dentist (PCD) may refer you to a specialist for certain types of care. Types of dental specialists include:

- Endodontists (for root canals)
- Pedodontist (for adults with special needs, and children)
- Periodontist (for gums)
- Orthodontist (in extreme cases, for braces)
- Oral surgeons (for extractions that require sedation or general anesthesia).

Common dental services that need to be referred to a specialist are:

- Oral Surgery
- Hospital-based dental care
- Root canals
- Gum issues
- In-office sedation

If you use a dental care provider that is not your primary care dentist, you may need a referral for these services:

- Oral exams
- Partial or complete dentures
- Extractions
- Root canal therapy

Please see the table on the next page for a list of what dental services are covered.
All covered services are free. These are covered as long as your provider says you need the services. Look at the "Service" column to see how many times you can get each service for free Look At the "In-network services" and "Out-of-network services" columns to see if you need to get a referral or preapproval for the service. If you see an * in the benefit charts, this means a service may be covered beyond the limits listed for members under 21, if medically necessary and appropriate. Please see pages 67-70 to learn more.

Service	In-network services	Out-of-network services	Who can get it
Care Coordination services Care coordination is a team of people that help you navigate the healthcare system. Examples include help scheduling appointments, communicating with your providers and care planning. There are no limits to the amount, duration, and scope of this benefit. See pages 29-34 for more information.	 No referral or preapproval	 No referral or preapproval	All members
Emergency and Urgent Dental care A dental emergency is when you need same-day dental care. Some examples are extreme pain or infection, bleeding or swelling, injuries to teeth or gums. There are no limits to the amount, duration, and scope of this benefit. Members have direct access to these services.	 No referral or preapproval.	 No referral or preapproval.	Members with dental coverage through UHA (CCOA, CCOG, and CCOF benefit plan type)
Oral Exams* These are regular check-ups for your teeth and mouth with your primary care dentist. **Members under 19 years old:** Twice a year* **All other members:** Once a year*	 No referral or preapproval.	 Referral needed if not seeing your primary care dentist	Members with dental coverage through UHA (CCOA, CCOG, and CCOF benefit plan type)

Service	In-network services	Out-of-network services	Who can get it
Oral Cleanings* During a cleaning, a dentist or dental hygienist will deep clean teeth and the mouth. They may perform other preventative services during the same visit. **Members under 19 years old:** Twice a year*, or as medically necessary **All other members:** Once a year*	 No referral or preapproval	 Referral needed if not seeing your primary care dentist	Members with dental coverage through UHA (CCOA, CCOG, and CCOF benefit plan type)
Fluoride varnish* This treatment is applied to the teeth and helps prevent tooth decay. **Members through age 18:** Twice a year* **Members through age 18 with high risk:** Four times per year* **Members 19 years old and up:** Once a year * **Members 19 years old and up with high risk:** Up to four times per year*	 No referral or preapproval, unless medically necessary.	 Referral needed if not seeing your primary care dentist	Members with dental coverage through UHA (CCOA, CCOG, and CCOF benefit plan type)

Service	In-network services	Out-of-network services	Who can get it
Oral X-rays* These are images of your teeth and jaw that dentists use to check your oral health. Covered once a year for all members (or as medically necessary for members birth to under age 21)*	 No referral or preapproval, unless medically necessary.	 Referral needed if not seeing your primary care dentist	Members with dental coverage through UHA (CCOA, CCOG, and CCOF benefit plan type)
Sealants* These are thin coatings on your teeth that help prevent cavities. **Members under age 16*:** on adult back teeth once every 5 years	 No referral or preapproval, unless medically necessary.	 Referral needed if not seeing your primary care dentist	Members under age 16 with dental coverage through UHA (CCOA, CCOG, and CCOF benefit plan type)
Fillings These are used to fix worn, decayed, or damaged teeth. Covered as needed for all members.	 No referral or preapproval, unless medically necessary.	 Referral needed if not seeing your primary care dentist	Members with dental coverage through UHA (CCOA, CCOG, and CCOF benefit plan type)

Service	In-network services	Out-of-network services	Who can get it
Partial or complete dentures* Dentures are removeable replacements for missing teeth and tissue in your mouth. They help you eat, speak, and smile comfortably. **Members 16 years and older*:** Partial: once every 5 years Complete: once every 10 years Denture reline is covered every three years for members under 20 years old and once every five years for members 21 years and older.*	 Preapproval needed  Referral needed if not seeing your primary care dentist	 Preapproval needed  Referral needed if not seeing your primary care dentist	Members with dental coverage through UHA (CCOA, CCOG, and CCOF benefit plan type)
Crowns* Crowns are caps for damaged teeth. **Pregnant members or members under age 21*:** Benefits vary by type of crown, specific teeth requiring care, age, and pregnancy status. Contact Advantage Dental for more information.	 Preapproval needed  Referral needed if not seeing your primary care dentist	 Preapproval needed  Referral needed if not seeing your primary care dentist	Members with dental coverage through UHA (CCOA, CCOG, and CCOF benefit plan type)

Service	In-network services	Out-of-network services	Who can get it
Partial or complete dentures* Dentures are removeable replacements for missing teeth and tissue in your mouth. They help you eat, speak, and smile comfortably. **Members 16 years and older*:** Partial: once every 5 years Complete: once every 10 years Denture reline is covered every three years for members under 20 years old and once every five years for members 21 years and older.*	 Preapproval needed  Referral needed if not seeing your primary care dentist	 Preapproval needed  Referral needed if not seeing your primary care dentist	Members with dental coverage through UHA (CCOA, CCOG, and CCOF benefit plan type)
Crowns* Crowns are caps for damaged teeth. **Pregnant members or members under age 21*:** Benefits vary by type of crown, specific teeth requiring care, age, and pregnancy status. Contact Advantage Dental for more information.	 Preapproval needed  Referral needed if not seeing your primary care dentist	 Preapproval needed  Referral needed if not seeing your primary care dentist	Members with dental coverage through UHA (CCOA, CCOG, and CCOF benefit plan type)

Service	In-network services	Out-of-network services	Who can get it
Extractions Your dentist will loosen and remove a tooth. A tooth may be removed because of infection, gum disease, or other problems. Covered as needed for all members.	 Referral needed if not seeing your primary care dentist	 Referral needed if not seeing your primary care dentist	Members with dental coverage through UHA (CCOA, CCOG, and CCOF benefit plan type)
Root Canal Therapy This procedure removes the damaged or infected part of a tooth. This helps prevent a tooth from needing to be extracted. **Members under 12 years old:** Not Covered on Third Molars (Wisdom Teeth). **Pregnant members:** Covered on First Molars. **All other members:** Covered Front Teeth and Pre-Molars.	 Preapproval needed for molars  Referral needed if not seeing your primary care dentist	 Preapproval needed for molars  Referral needed if not seeing your primary care dentist	Members with dental coverage through UHA (CCOA, CCOG, and CCOF benefit plan type)
Orthodontics* Orthodontics is a specialty type of dental care. It helps diagnose and treat teeth and jaw problems, such as misalignment. Types of treatments used include braces and retainers. **For members birth to under age 21*:** In cases such as cleft lip and palate, handicapping malocclusion, or when speech, chewing and other functions are affected. It is required to have approval from your dentist and to not have any cavities or gum disease.	 Preapproval needed	 Preapproval needed	Members with dental coverage through UHA (CCOA, CCOG, and CCOF benefit plan type)

The table is not a full list of services that need preapproval or referral. If you have questions, please call Advantage Dental Services at 866-268-9631 (TTY 711).

Veteran and Compact of Free Association (COFA) Dental Program Members

If you are a member of the Veteran Dental Program or COFA Dental Program ("OHP Dental"), UHA **only** provides dental benefits and free rides to dental appointments.

OHP and UHA do not provide access to physical health or behavioral health services or free rides for these services, which are non-covered services without care coordination. If you have questions regarding coverage and what benefits are available contact Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711.

Prevention is Important!

We want to prevent health problems before they happen. You can make this an important part of your care. Please get regular health and dental checkups to find out what is happening with your health.

Some examples of preventive services:

- Shots for children and adults
- Dental checkups and cleanings
- Mammograms (breast X-rays)
- Pap smear
- Pregnancy and newborn care
- Exams for wellness
- Prostate screenings for men
- Yearly checkups
- Well-child exams

A healthy mouth also keeps your heart and body healthy.

If you have any questions, please call us at 541-229-4842, TTY 541-440-6304 or TTY 711.

Tobacco Use

Tobacco cessation products are covered by UHA. The best thing you can do for your health and your family's health is to stop using tobacco. If you want to quit smoking or chewing tobacco, please call UHA Customer Care. We have resources to help you quit.

Did you know?

- Within 12 hours of quitting, the carbon monoxide levels in your blood return to normal.
- 1 Year after you quit, your risk of heart disease is cut in half.
- 5 Years after you quit, your risk of having a stroke is the same as a non-smoker.

Adapt has a patient-centered care approach geared towards helping people with their nicotine use. They offer:

- Assessment for tobacco use
- One on one counseling

- Custom treatment plans
- Services for youth and adults
- Information about stop smoking medications
- Mayo Clinic's quit guide "My Path to a Smoke Free Future"
- Relapse prevention and education
- Referrals to additional support services when needed

Contact Adapt today to get started on your road to a tobacco free life!

- Phone: 541-492-0152
- Online: www.adaptoregon.org
- Address: 621 W Madrone St, 2nd Floor
  Roseburg, OR 97470

Stop Smoking Programs

- Oregon Tobacco Quit Line:
  - English: 1-800-QUIT-NOW (1-800-784-8669)
  - Español: 1-855-DEJELO-YA
  - TTY: 1-877-777-6534
  - Online: www.quitnow.net/oregon

Other Sources to Consider to Help Stop Smoking:

- Smoke Free: smokefree.gov/
- Teen: teen.smokefree.gov/
- VA: smokefree.gov/tools-tips-vet/smokefreevet

Freedom from Smoking:

- Online: www.freedomfromsmoking.org/
- Toll Free: 800-586-4872

Nicotine Anonymous:

- Online: nicotine-anonymous.org/

Services that OHP pays for

UHA pays for your care, but there are some services that we do not pay for. These are still covered and will be paid by the Oregon Health Plan's Fee-For-Service program. CCOs sometimes call these services "non-covered" benefits. There are two types of services OHP pays for directly:

1. Services where you get care coordination from UHA.
2. Services where you get care coordination from OHP.

Services with UHA care coordination

UHA still gives you care coordination for some services. For assistance, you can get free rides from Bay Cities Brokerage (BCB) for covered services, as well as support activities and any resources you need for non-covered services.

UHA will coordinate your care for the following services:

- Planned Community Birth (PCB) services include prenatal and postpartum care for people experiencing low risk pregnancy as determined by the OHA Health Systems Division. OHA is responsible for providing and paying for primary PCB services including at a minimum, for those members approved for PCBs, newborn initial assessment, newborn bloodspot screening test, including the screening kit, labor and delivery care, prenatal visits and postpartum care.
- Long term services and supports (LTSS) not paid by UHA.
- Helping members to get access to behavioral health services. Examples of these services are:
    - Certain medications for some behavioral health conditions
    - Therapeutic group home payment for members birth to under age 21
    - Long term psychiatric (behavioral health) care for members 18 years old and older
    - Personal care in adult foster homes for members 18 years and older
- And other services

For more information or for a complete list about these services, call Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711.

Services that OHP pays for and provides care coordination

OHP will coordinate your care for the following services:

- Comfort care (hospice) services for members who live in skilled nursing facilities.
- School-based services that are provided under the Individuals with Disabilities Education Act (IDEA). For children who get medical services at school, such as speech therapy.
- Medical exam to find out if you qualify for a support program or casework planning
- Abortions and other procedures to end pregnancy.
- Doctor aided suicide under the Oregon Death with Dignity Act and other services

Contact OHP's Acentra (formally known as KEPRO) Care Coordination team at 800-562-4620 for more information and help with these services.

You can still get a safe and timely ride that is right for you from BCB for any of these services at no cost to you. See pages 75-79 for more information. Call BCB at 877-324-8109 to schedule a ride or ask questions.

Moral or Religious objections

UHA does not limit services based on moral or religious objections.

Access to the care you need

Access means you can get the care you need. You can get access to care in a way that meets your cultural and language needs. If UHA does not work with a provider who meets your access needs, you can get these services out-of-network. UHA makes sure that services are close to where you live or close to where you want care. This means that there are enough providers in the area and there are different provider types for you to pick from.

We keep track of our network of providers to make sure we have the primary care and specialist care you need. We also make sure you have access to all covered services in your area. We do this by reviewing:

- Grievances (complaints) and appeals from members.
- The types of member grievances filed.
- How services are used.

- Requests for out-of-network services.
- Requests for special accommodations.
- Requests for second opinions.
- Community health assessments.
- Member satisfaction survey results.

UHA follows the state's rules about how far you may need to travel to see a provider. The rules are different based on the provider you need to see and the area you live in. Primary Care Providers are "Tier 1", meaning they will be closer to you than a specialist like Dermatology, who is "Tier 3". If you live in a remote area it will take longer to get to a provider than if you live in an urban area.

The chart below lists the tiers of providers and the time (in minutes) or distance (in miles) of where they are located based on where you live.

	Large Urban	Urban	Rural	County with Extreme Access Considerations
Tier 1	10 mins or 5 miles	25 mins or 15 miles	30 mins or 20 miles	40 mins or 30 miles
Tier 2	20 mins or 10 miles	30 mins or 20 miles	75 mins or 60 miles	95 mins or 85 miles
Tier 3	30 mins or 15 miles	45 mins or 30 miles	110 mins or 90 miles	140 mins or 125 miles

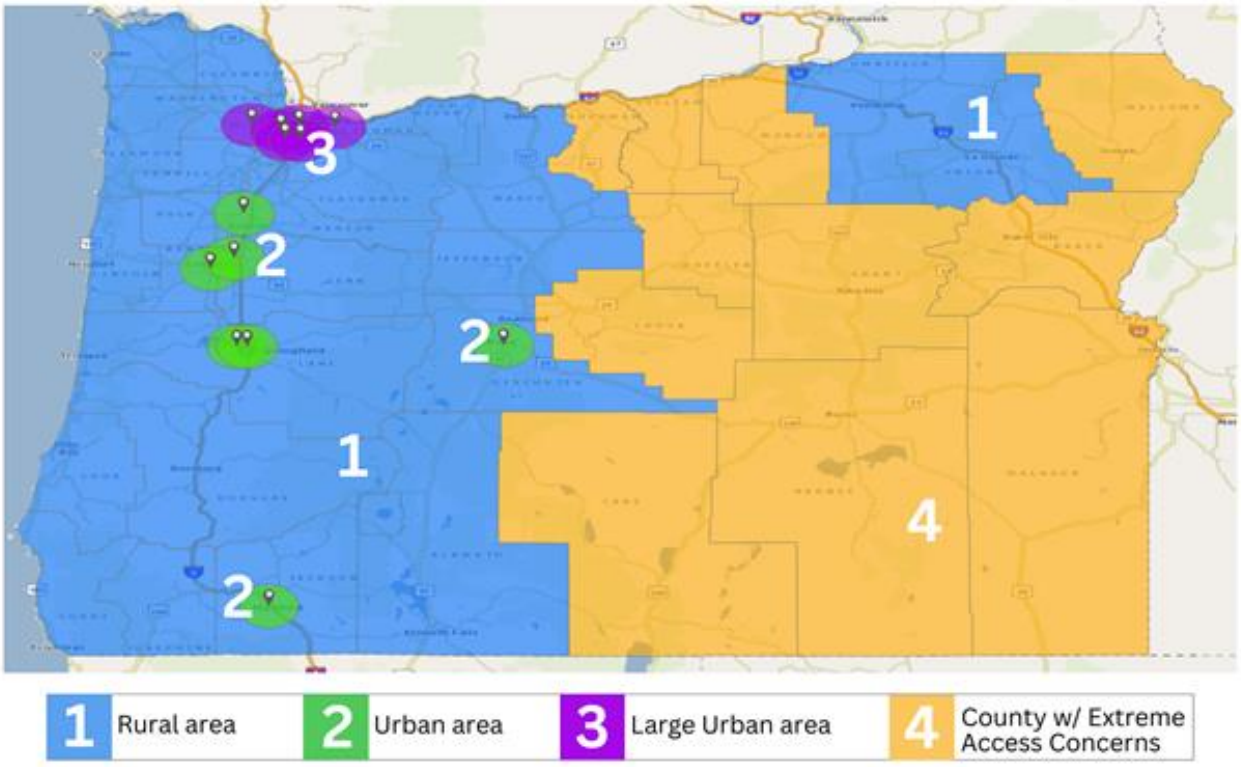
For more information about what providers fall into the different tiers, go to OHA's Network Adequacy website at: www.oregon.gov/oha/HSD/OHP/Pages/network.aspx.

Tier	Provider Type
Tier 1	Primary Care, Primary Care Dentistry, Imaging, Mental Health, Pharmacy, SUD Treatment
Tier 2	Cardiology, Chiropractor, Durable Medical Equipment, Gynecology, Hospital, Methadone Clinic, Neurology, Obstetrics, Occupational Therapy, Oncology – Medical, Ophthalmology, Optometry, Pain Medicine, Physical Therapy, Podiatry, Psychiatry, Psychology, Speech Language Pathology
Tier 3	Acupuncture, Allergy & Immunology, Audiology, Dermatology, Endocrinology, ENT/Otolaryngology, Gastroenterology, Hematology, Nephrology, Pulmonology, Rheumatology, Skilled Nursing Facility, Urology

Not sure what kind of area you live in? See the map on the next page.

Area Types:

- **Large Urban (3):** Connected Urban Areas, as defined above, with a combined population size greater than or equal to 1,000,000 persons with a population density greater than or equal to 1,000 persons per square mile.
- **Urban (2):** Less than or equal to 10 miles from center of 40,000 or more.
- **Rural (1):** Greater than 10 miles from center of 40,000 or more with county population density greater than 10 people per square mile.
- **County with Extreme Access Concerns (4):** Counties with 10 or fewer people per square mile.



Douglas County is a rural area. Our providers will also make sure you will have physical access, reasonable accommodations and accessible equipment if you have physical and/or mental disabilities. To get these services, please let your provider know what your needs are. Providers also make sure office hours are the same for OHP members and everyone else.

How long it takes to get care

We work with providers to make sure that you will be seen, treated, or referred within the times listed on the next page.

Care type	Timeframe
Physical health	
Regular appointments	Within 4 weeks
Urgent care	Within 72 hours or as indicated in the initial screening.
Emergency care	Immediately or referred to an emergency department depending on your condition.
Oral and dental care for children and non-pregnant people	
Regular oral health appointments	Within 8 weeks unless there is a clinical reason to wait longer.
Urgent oral care	Within 2 weeks.
Dental Emergency services	Seen or treated within 24 hours
Oral and dental care for pregnant people	
Routine oral care	Within 4 weeks unless there is a clinical reason to wait longer.
Urgent dental care	Within 1 week
Dental emergency services	Seen or treated within 24 hours
Behavioral health	
Routine behavioral healthcare	All members have the right to access: • Assessments withing 7 days of their request for an appointment • Second appointments scheduled as clinically appropriate.
Urgent behavioral healthcare for all populations	All members have the right to access within 24 hours
Specialty behavioral healthcare for priority populations*	
Members of the priority populations include: • Pregnant people, • Veterans and their families, • People with children, • Unpaid caregivers, • Families, • Children ages 0-5 years, • People with HIV/AIDS • People with tuberculosis • People at the risk of first episode psychosis • People with intellectual and/or developmental disabilities	Priority population members have the right to: • Immediate assessment and entry. If services are not available to you immediately: • Providers must offer you interim services until the service(s) you need are available. Interim services must be similar to the ones you need. If you are placed on a waitlist: • You should never wait more than 120 days for services. You must be offered the service(s) you need after being placed on a waitlist. Contact UHA if you cannot receive services in these time frames.

Care type	Timeframe
• IV drug users including heroin	Members that use needles to misuse substances have the right to access: • Immediate assessment(s) • Immediate entry to services • Residential treatment within 14 days of referral If you have been put on a waitlist because there are no providers available, you will be placed for services within 120 days. Contact UHA if you cannot receive services in these time frames.
• People with opioid use disorder	Members that have Opioid Use Disorder have the right to access: • Immediate assessment(s) within 72 hours • Immediate entry to services within 72 hours • Residential treatment within 14 days of referral If you are placed on a waitlist: • You should never wait more than 120 days for services. You must be offered the service(s) you need after being placed on a waitlist. Contact UHA if you cannot receive services in these time frames.
• People who are on Medication assisted treatment	Members have the right to receive services as soon as possible: • Assessment(s) within 72 hours • Entry to services within 72 hours Contact UHA if you cannot receive services within 72 hours.

* For specialty behavioral healthcare services if there is no room or open spot:

- You will be put on a waitlist.
- You will have other services given to you within 72 hours.
- These services will be temporary until there is a room or an open spot.

If you have any questions about access to care, call Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711.

Comprehensive and preventive benefits for members under age 21

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for OHP members from birth to under age 21.

This benefit provides you with the care you need for your health and development. These services can catch and help with concerns early, treat illness, and support children with disabilities.

You do not have to enroll separately in EPSDT; members birth to under age 21 and enrolled in OHP will receive these benefits at no cost.

The EPSDT benefit covers:

- Any services needed to find or treat illness, injury, or other changes in health.
- "Well-child" or "adolescent well visit" medical exams, screenings, and diagnostic services to determine if there are any physical, oral/dental, developmental and mental health conditions for members birth to under age 21.
- Referrals, treatment, therapy, and other measures to help with any conditions discovered.

For members birth to under age 21, UHA has to give:

- Regularly scheduled examinations and evaluations of physical, mental health, developmental, oral/dental health, growth, and nutritional status.
    - If UHA doesn't cover oral/dental health, you can still get these services through OHP by calling 1-800-273-0557.
    - Starting January 1, 2023, all medically necessary and medically appropriate services must be covered for members birth to under age 21, regardless of whether it was covered in the past (this includes things that are "below the line" on the Prioritized List). To learn more about the Prioritized list, see page 34.

Under EPSDT, UHA will not deny a service without first looking at whether it is medically necessary and medically appropriate for you.

- *Medically necessary* generally means a treatment that is required to prevent, diagnose, or treat a condition, or to support growth, development, independence, and participation in school.
- *Medically appropriate* generally means that the treatment is safe and effective, and helps you participate in care and activities. UHA may choose to cover the least expensive option that will work for you.

You should always receive a written notice when something is denied, and you have the right to an appeal if you don't agree with the decision. For more information, see pages 102-107.

This includes *all* services:

- Physical health.
- Behavioral health.
- Oral/Dental health; and
- Social health care needs.

If you or your family member needs EPSDT services, work with your primary care provider (PCP) or talk to a care coordinator by calling 541-229-4842, TTY 541-440-6304 or TTY 711. They will help you get the care you need. If any services need approval, they will take care of it. Work with your primary care dentist for any needed dental services. All EPSDT services are free.

Help getting EPSDT services

- Call Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711.

- Call Advantage Dental Services at 866-268-9631 to set up dental services or for more information.
- You can free get rides to and from covered EPSDT provider visits. Call BCB at 877-324-8109 to set up a ride or for more information.
- You can also ask your PCP or visit our website at: www.umpquahealth.com/services/ for a copy of the periodicity schedule. This schedule tells you when children need to see their PCP.

Screenings

Covered screening visits are offered at age-appropriate intervals (these include well child visits or adolescent well visits). UHA and your PCP follows the American Academy of Pediatrics and Bright Futures guidelines for all preventive care screenings and well child visits. Bright Futures can be found at: brightfutures.aap.org/Pages/default.aspx. Your PCP will help you get these services and treatment when required by the guidelines.

Screening visits include:

- A health and developmental screening. This includes:
  - Mental development
  - Physical development
- Lead testing:
  - Children must have blood lead screening tests at age 12 months and 24 months. Any child between ages 24 and 72 months with no record of a previous blood lead screening test must get one.
  - Completion of a risk assessment questionnaire does not meet the lead screening requirement for children in OHP. All children with lead poisoning can get follow up case management services.
- Other needed laboratory tests (such as anemia test, sickle cell test, and others) based on age and risk.
- Assessment of nutritional status.
- Overall unclothed physical exam with an inspection of teeth and gums.
- Full health and development history (including review of both physical and mental health development).
- Immunizations (shots) that meet medical standards:
  - Child Immunization Schedule (birth to 18 years): www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html
  - Adult Immunization Schedule (19+): https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html
- Health guidance and education for parents and children.
- Referrals for medically necessary physical and mental health treatment.
- Needed hearing and vision tests.
- And others.

Covered visits also include unscheduled check-ups or exams that can happen at any time because of illness or a change in health or development.

EPSDT screening services can be done by:

- Medical Doctor (MD)
- Doctor of Osteopathic Medicine (DO)

- Physician Assistant (PA)
- Nurse Practitioner (NP)
- Any licensed health care provider

Any of the above providers can refer you to a dentist to provide EPSDT services.

EPSDT: referral, diagnosis and treatment

Your primary care provider may refer you if they find a physical, mental health, substance abuse, or dental condition. Another provider will help with more diagnosis and/or treatment.

The screening provider will explain the need for the referral to the child and parent or guardian. If you agree with the referral, the provider will take care of the paperwork. You can also call UHA Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711 if you need help finding a provider or scheduling an appointment. UHA or OHP will also help with care coordination, as needed.

Screenings may find a need for the following services, as well as others:

- Diagnosis of and treatment for impairments in vision and hearing, including eyeglasses and hearing aids.
- Dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health.
- Immunizations (if it is determined at the time of screening that immunization is needed and appropriate to provide at the time of screening, then immunization treatment must be provided at that time).

These services must be provided to eligible members birth to under age 21 who need them. Treatments that are “below the line” on the Prioritized List of Health Services are covered for members birth to under age 21 if they are medically necessary and medically appropriate for that member (see more information above).

- If we tell you that the service is not covered by OHP, you still have the right to challenge that decision by filing an appeal and asking for a hearing. See pages 102-107.

UHA will give referral help to members or their representatives for social services, education programs, nutrition assistance programs, and other services.

For more information about EPSDT coverage, you can visit www.Oregon.gov/EPSDT and view a member fact sheet. UHA also has information at www.umpquahealth.com/services.

Traditional Health Workers (THW)

Traditional Health Workers (THW) help with questions you have about your health care and social needs. They help with communication between your health care providers and other people involved in your care. They also connect with people and services in the community that can help you. THW services do not require a referral.

There are a few different kinds of traditional health workers:

- **Birth Doula:** A person who helps people and their families with personal, non-medical support. They help through pregnancy, childbirth, and after the baby is born.
- **Community Health Worker:** A public health worker understands the people and community where you live. They help you access health and community services. A community health

worker helps you start healthy behaviors. They usually share your ethnicity, language, or life experiences.

- **Personal Health Navigator:** A person who gives information, tools, and support to help you make the best decisions about your health and wellbeing, based on your situation.
- **Peer Support Specialist:** Someone who has life experiences with mental health, addiction and recovery. Or they may have been a parent of a child with mental health or addiction treatment. They give support, encouragement, and help to those facing addictions and mental health issues. They can help you through the same things.
- **Peer Wellness Specialist:** A person who works as part of a health home team and speaks up for you and your needs. They support the overall health of people in their community and can help you recover from addiction, mental health, or physical conditions.
- **Tribal Traditional Health Workers:** Someone who helps tribal or urban Indian communities improve their overall health. They provide education, counseling, and support which may be specific to tribal practices.

A THW can help you with many things, like:

- Finding a new provider.
- Receiving the care, you need.
- Understanding your benefits.
- Providing information on behavioral health services and support.
- Advice on community resources you could use.
- Someone to talk to from your community.

All UHA members are eligible to receive THW services. Our Lead Care Coordination Navigator is also our THW Liaison. Contact them at 541-673-8982 or email CaseManagement@umpquahealth.com to find out more about UHA's THW staff and how to use their services.

If we change the contact information for the THW liaison, you can find up-to-date information on our website at: www.umpquahealth.com/case-management/.

Extra services

In Lieu of Services (ILOS)

UHA offers services or settings that are medically appropriate alternatives to services covered by OHP. These are called "in lieu of services" (ILOS). They are offered as helpful options for members. UHA has contracted with Oregon Wellness Network (OWN) to offer the following ILOS:

- **Diabetes Self-Management Education & Support (DSMES)**
  - These services are designed for members with diabetes. There are two parts to this program:
    - Online training, support, and help given by a trained diabetes educator or lifestyle coach.
    - Individual or group sessions that meet each week for six weeks. These services aim to help you manage your diabetes and promote healthy habits.
- **National Diabetes Prevention Program (National DPP)**
  - A Centers for Disease Control (CDC) recognized online program offered by the National Diabetes Prevention Program (National DPP). This is a year-long program that helps members:
    - Lose weight.

        - Adopt healthier habits.
        - Help reduce their risk of type 2 diabetes.
- **Community Health Workers (CHW) in Alternative Setting**
    - You can meet with a CHW in community settings, such as housing or social service agencies. They will help you get needed services without the need for an office, or other outpatient visits.

Deciding if an ILOS is right for you is a team effort. We work with your care team to make the best choice. The choice, however, is yours. You do not have to take part in any of these programs. If you have any questions about any of the benefits or services above, call Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711.

If an ILOS is no longer going to be offered, UHA will let you know by mail at least 30 days before the change happens. Members have a right to file an appeal, or a grievance, for covered services that are fully or partially denied. For more information on appeals and grievances, please see pages 101-107.

Health-Related Services

Health-Related Services (HRS) are extra services UHA offers. HRS help improve overall member and community health and well-being. HRS are flexible services for members and community benefit initiatives for members and the larger community.

The UHA HRS program aids in the best use of funds to address individual health needs, as well as social risk factors, like where you live, to improve community well-being. Learn more about health-related services at sharedsystems.dhsoha.state.or.us/DHSForms/Served/le4329.pdf.

Flexible Services

Flexible services are support for items or services to help members become or stay healthy. UHA offers these flexible services:

- Food supports, such as grocery delivery, food vouchers, or medically tailored meals
- Short-term housing supports, such as rental deposits to support moving costs, rent support for a short period of time, or utility set-up fees
- Temporary housing or shelter while recovering from hospitalization
- Items that support healthy behaviors, such as athletic shoes or clothing
- Mobile phones or devices to be seen by your provider
- Other items that keep you healthy, such as an air conditioner or air filter

How to get flexible services for you or family member

You can work with your provider to request flexible services or you can call Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711 and have a request form sent to you in the language or format that fits your needs. You can also get our flexible services form on our website at www.umpquahealth.com/hrsflex. This page will tell you what rules we follow when reviewing requests. It will also tell you what documentation UHA needs to review.

Flexible services are not a covered benefit for members and CCOs are not required to provide them. Decisions to approve or deny flexible services requests are made on a case-by-case basis. If your flexible service request is denied, you will get a letter explaining your options. You can’t appeal a denied flexible service but you have the right to make a complaint. Learn more about appeals and complaints on pages 101-107.

If you have OHP and have trouble getting care, please reach out to the OHA Ombuds Program. The Ombuds are advocates for OHP members and they will do their best to help you. Please email OHA.OmbudsOffice@odhsoha.oregon.gov or leave a message at 877-642-0450.

Another resource for supports and services in your community is 211 Info. Call 2-1-1 or go to the www.211info.org website for help.

Community Benefit Initiatives

Community benefit initiatives are services and supports for members and the larger community to improve community health and well-being.

Each year, UHA supports projects and programs that further our community health improvement plan, or CHP. Examples of these community benefit initiatives are:

- Community-based programs that help families access fresh fruits and veggies through farmers' markets.
- Trainings on trauma informed practices.
- Gardening opportunities for low income housing units.
- Lifestyle Nutrition and Education classes.
- And more!

Examples of other community benefit initiatives are:

- Classes for parent education and family support
- Active transportation improvements, such as safe bicycle lanes and sidewalks
- School-based programs that support a nurturing environment to improve students' social-emotional health and academic learning
- Training for teachers and child-specific community-based organizations on trauma informed practices

For more information on UHA's community benefit initiatives and other community projects, you can visit our website at www.umpquahealth.com/communityimpact/.

Oral Health Community Care

We proudly support members getting oral health services in community settings. Advantage Dental Services sends dental hygienists with a special permit into schools, Women Infants Children (WIC), Head Start, Medical offices, long-term care facilities and other community locations to complete assessments. They also do some preventive services while they are there, like fluoride or silver fluoride and help people understand how to take care of their teeth.

In places where we don't have a hygienist to do this, we work with other organizations. Services you have in the community should be free to you if they are covered on your plan. If you aren't sure, you can ask the person who is doing the services, or you can call Customer Care.

Health Related Social Needs

Health-Related Social Needs (HRSN) refer to barriers to health, like housing or access to food. Please contact UHA to see what free HRSN Services are available. HRSN Services include:

- Housing Services: Help with rent and utilities, to get or keep housing, moving costs, and home modifications. This will begin no sooner than November 1, 2024, and will be for members at risk of becoming houseless. For others, this service will start at a later date.

- Climate Services: Help to get health related air conditioners, heaters, air filters, portable power supplies and mini fridges. This will begin in March 2024.
- Nutrition Services: Includes nutrition education, medically tailored meals, meals or pantry stocking, fruit and vegetable prescriptions. This will begin January 1, 2025.

You may be eligible to receive some or all of the HRSN Services if you are an OHP Member, and:

- Are homeless or at risk of being homeless.
- Are being discharged from an Institute for Mental Disease.
- Are being released from incarceration.
- Are a youth transitioning out of the child welfare system.
- Are a Youth with Special Healthcare Needs (cannot receive services until 2025).
- Are an individual who is transitioning to dual status with OHP and Medicare.

You must also meet certain criteria. To be screened for HRSN, please contact UHA. We can help you to schedule appointments for HRSN Services, including the screening.

You are able to ask to be screened for eligibility or to deny screening for eligibility. If approved, you can choose to receive or not receive HRSN Services. If approved, HRSN Services are free to you and you can opt out at any time. If you receive HRSN Services, your care coordination team will work with you to make sure your care plan includes the services you receive. See pages 29-34 for Care Coordination and care plans.

Please note that to be screened for and receive HRSN Services, your personal data may be collected and used during referrals. You have the ability to limit the way in which your information is shared.

If you need help scheduling appointments for HRSN Services, contact UHA Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711.

OHP Bridge for adults with higher incomes starts July 1, 2024

OHP Bridge is a new Oregon Health Plan (OHP) benefit package that covers adults with higher incomes. People who can get OHP Bridge must:

- Be 19 to 65 years old;
- Have an income between 139 percent and 200 percent of the federal poverty level (FPL);
- Have an eligible citizenship or immigration status to qualify; and,
- Not have access to other affordable health insurance.

Learn more about OHP Bridge eligibility at
https://www.oregon.gov/oha/hsd/ohp/pages/bridge.aspx.

OHP Bridge is almost the same as OHP Plus.

The two benefit packages are almost the same. There are a few things that OHP Bridge does not cover. To learn more about what OHP Bridge does not cover, please see the table on the next page.

What OHP Bridge covers	What OHP Bridge does not cover
Medical, dental, and behavioral health care. Learn more on pages 38-60.	Long-term services and supports. Learn more on page 63.
Free rides to care. Learn more on pages 75-79.	Health Related Social Needs. Learn more on pages 73-74.

OHP Bridge is free to members.
Just like OHP Plus, OHP Bridge is free to members. That means no premiums, no co-payments, no coinsurance, and no deductibles.

OHP members with income changes may be moved to OHP Bridge automatically.
If you have OHP now, you don't have to do anything to get OHP Bridge. If you report a higher income when you renew your OHP, you may be moved to OHP Bridge.

People who do not have OHP right now can apply for OHP Bridge.
Go to Benefits.Oregon.gov to apply. You can also use that link to find information about how to apply in person, get application help, or to get a paper application. To apply over the phone, call the ONE Customer Service Center at 1-800-699-9075 (toll-free, all relay calls are accepted).

Free rides to care

Free rides to appointments for all UHA members.

If you need help getting to an appointment, call Bay Cities Brokerage (BCB) for a free ride. You can get a free ride to any physical, dental, pharmacy, or behavioral health visit that is covered by UHA.

You or your representative can ask for a ride. BCB may give you a bus ticket, money for a taxi, or have a driver pick you up. BCB may pay gas money to you, a family member, or a friend to drive you. There is no cost to you for this service. UHA will never bill you for rides to or from covered services.

Schedule a ride

Call BCB at 877-324-8109 (TTY 711)
Hours: Monday through Friday, 8:00 a.m. to 5:00 p.m. If calling after hours, there is a 24-hour hotline available. BCB's call center is closed on the following holidays:

- New Year's Day (01/01/24)
- Memorial Day (05/27/24)
- Independence Day (07/04/24)
- Labor Day (09/02/24)
- Thanksgiving (11/28/24)
- Christmas Day (12/25/24)

You can also go on their website to schedule a ride: bca-ride.com.

Please call at least 2 business days before the appointment to schedule a ride. This will help make sure BCB can meet your ride needs. You can also get a same or next-day ride. You or someone you know can set up more than one ride at a time for multiple appointments. You can schedule rides for future appointments up to 90 days in advance.

What to expect when you call

BCB has a rides call center staff who can help in your preferred language and in a way that you can understand. This help is free.

The first time you call BCB will tell you about the program and talk about your ride needs. BCB will ask about your physical ability and if you will need someone to travel with you.

When you call to schedule a ride, BCB will ask for:

- Your full name.
- Your address and phone number.
- Your date of birth.
- Name of the doctor or clinic you need to visit.
- Date of appointment.
- Time of appointment.
- Pick-up time after appointment.
- If you need an attendant to help you.
- Any other special needs (like a wheelchair or service animal).

BCB will check to see if you are with UHA and if your appointment is for a service that's covered. You will get more information about your ride within 24 hours. You will get information about your ride request in a way you choose (phone call, email, fax).

If you request a ride less than two (2) days before the scheduled pick-up time, BCB will give you the phone number of the company who will arrange for your pick-up. BCB may, but does not have to, give you the name and phone number of the driver who will pick you up.

Pick up and drop off

You'll get the ride company or driver's name and number before your appointment. Your driver will contact you at least 2 days before your ride to confirm details. They will pick you up at your scheduled time. Please be on time. If you are late, they will wait for 15 minutes after your scheduled time. That means if your ride is scheduled for 10 a.m., they will wait for you until 10:15 a.m.

They will drop you off for your appointment at least 15 minutes before it starts.

- **First appointment of the day:** BCB will drop you off no more than 15 minutes before the office opens, unless requested by you or your guardian, parent, or representative.
- **Last appointment of the day:** BCB will pick you up no later than 15 minutes after the office closes, unless the appointment is not expected to end within 15 minutes after closing, unless requested by you or your guardian, parent, or representative.
- **Asking for more time:** You must ask to be picked up earlier or dropped off later than these times. Your representative, parent or guardian can also ask BCB.
- **Call if your driver has not arrived by 10 minutes after pickup time:** If your driver has not arrived by 10 minutes after your scheduled pickup time, call the ride company. Staff will let you know if the driver is on their way. Drivers must tell the dispatcher before leaving from the pick-up location.
  Call if you don't have a pickup time: If there is no scheduled pickup time for your return trip, call BCB when you are ready. Your driver will be there within 1 hour after you call.

BCB is a shared ride program. Other passengers may be picked up and dropped off along the way. If you have several appointments, you may be asked to schedule on the same day. This will help BCB to make fewer trips.

Mileage reimbursement

You can contact BCB to get reimbursement forms. You may need prior approval or provider confirmation of visit for reimbursement requests for meals and lodging to covered health services to qualify for reimbursement. Please contact BCB to see if prior approval is needed. Prior to receiving reimbursement, you must return all required documents to UHA or BCB. BCB may hold refunds if the amount is less than $10.00 until the members refund reaches $10.00.

You may ask to have a friend or family member drive you to the appointment. They can get reimbursed (paid) for the miles they drive.

The reimbursement amounts are as follows:

- Mileage: $0.44/mile.
- Meal Reimbursements - Travel must be a minimum of (4) four hours outside of your local area. Members do not need to submit receipts for meals.
    - Breakfast: $6.50 - Travel must begin before 6:00 am.
    - Lunch: $7.50 - You must be gone the entire period from 11:30 am to 1:30 pm.
    - Dinner: $13.00 - Travel ends after 6:30 pm.
- Lodging reimbursement is available if the travel begins before 5:00 am in order to reach a scheduled appointment or if travel from a scheduled appointment would end after 9:00 pm. Lodging is not reimbursed if the trip can be completed in one day or for multiple appointments on different days when they can be scheduled the same day.
    - Lodging Amount: $98.00 per night.

You can mail reimbursement forms to BCB or drop them off at their local address:

Mailing address:
Bay Cities Brokerage
3505 Ocean Blvd SE
Coos Bay, OR 97420

Local Address:
Umpqua Valley Ambulance
1290 NE Cedar St
Roseburg, OR 97470

You have rights and responsibilities as a rider:

You have the right to:

- Get a safe and reliable ride that meets your needs.
- Be treated with respect.
- Ask for interpretation services when talking to Customer Care or BCB.
- Get materials in a language or format that meets your needs.
- Get a written notice when a ride is denied.
- File a complaint about your ride experience.
- Ask for an appeal, ask for a hearing, or ask for both if you feel you have been denied a ride service unfairly.

Your responsibilities are to:

- Treat drivers and other passengers with respect.
- Call BCB as early as possible to schedule, change, or cancel a ride
- Use seatbelts and other safety equipment as required by law (example: car seats).
- Ask for any additional stops, like the pharmacy, in advance.

Cancel or change your ride

Call BCB when you know you need to cancel or reschedule your ride, at least 2 hours before the pick-up time.

You can call BCB Monday through Friday, 8:00 a.m. to 5:00 p.m. If calling after hours, there is a 24-hour hotline available. You can also go online to cancel or reschedule your ride: bca-ride.com. Call BCB at 877-324-8109 if you have any questions or ride changes.

When you don't show up

A "no-show" is when you aren't ready to be picked up on time. Your driver will wait at least 15 minutes after the scheduled pick-up time before leaving. BCB may restrict your future rides if you have too many no-shows.

Having a restriction means BCB might limit the number of rides you can make, limit you to one driver, or require calls before each ride.

If your ride is denied

You will receive a call to let you know that your ride is denied. All denials are reviewed by two staff members before sent to you. If your ride is denied, BCB will mail you a denial letter within 72 hours of the decision. The notice states the rule and reason for the denial.

You can ask for an appeal with UHA if you do not agree with the denial. You have 60 days from the date of the denial notice to request an appeal. After the appeal, if the denial stands you also have the right to request a State hearing.

BCB will mail your provider a letter as well if the provider is part of our provider network and they requested the transportation on your behalf.

You have the right to make a complaint or grievance at any time, even if you have made the complaint before. Some examples of a complaint or grievance are:

- Concerns about vehicle safety
- Quality of services
- Interactions with drivers and providers (such as rudeness)
- Ride service requested was not provided as arranged
- Consumer rights

Learn more about complaints, grievances, appeals and hearings on pages 101-107.

Rider Guide

Get the BCB Rider Guide at: www.umpquahealth.com/get-a-ride/. You or your representative can also call Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711 to ask for a free paper copy. It will be sent in 5 business days. The paper copy can be in the language and format you prefer.

The guide has more information, like:

- Wheelchairs and mobility help.
- Vehicle safety.
- Driver duties and rules.

- What to do in an emergency or if there is bad weather.
- Long distance appointments.
- Meal and lodging reimbursement.

Getting care by video or phone

Telehealth (also known as telemedicine and teledentistry) is a way for you to get care without going into the clinic or office. Telehealth means you can have your appointment through a phone call or video call. UHA will cover telehealth visits. To get telehealth, you need a phone, tablet, or other device that supports video and phone capabilities. UHA does not provide or support these technologies. This service is provided by our contracted providers. If you do not have a device for a telehealth visit but must been seen via telehealth, contact UHA for more help. We can offer other possible solutions. If you do not have internet or video access, you can also talk to your provider about what will work for you. Telehealth services are free.

How to find telehealth providers

Not all providers have telehealth options. You should ask about telehealth when you call to make your appointment. To find a provider that provides these services, you can go on-line in the Provider Directory at portal.umpquahealth.com/ClientApp/providers.

If you have any audio or video problems with your telehealth visit, please be sure to work with your provider.

Below is a list of community health centers that can provide telehealth services for you needs:

- **Evergreen Family Medicine** offers video and phone telehealth services.
- **Aviva Health** offers video and phone telehealth services.
- **Cow Creek** offers phone telehealth services.
- **Umpqua Health Newton Creek** offer video and phone telehealth services.
- **Adapt Primary Care** has a website called doxy.me for telehealth services.
    - To access this free service, go to doxy.me/sign-in. This may not work on all browsers.

When to use telehealth

UHA members using telehealth have the right to get the physical, dental, and behavioral health services they need. Some examples of when you can use telehealth are:

- When your provider wants to visit with you before refilling a prescription.
- Counseling services.
- Following up from an in-person visit.
- When you have routine medical questions.
- If you are quarantined or practicing social distancing due to illness.
- If you are not sure if you need to go into the clinic or office.

Telehealth is not recommended for emergencies. If you feel like your life is in danger, please call 911 or go to the nearest emergency room. See page 82 for a list of hospitals with emergency rooms.

Telehealth visits are private

Telehealth services offered by your provider are secure. Each provider will have their own system for telehealth visits, but each system must follow the law.

Learn more about privacy and the Health Insurance Portability and Accountability Act (HIPAA) on page 12.

Make sure you take your call in a private room or where no one else can listen in on your appointment with your provider.

You have a right to:

- Get telehealth services for covered physical, behavioral or oral health benefits that fit your needs.
- Get telehealth services in the language you need.
- Have providers that respect your culture and language needs.
- Get qualified and certified interpretation services for you and your family. Learn more on pages 3-5.
- Get in-person visits, not just telehealth visits.
    - UHA will make sure you have the choice of how you get your visits. A provider cannot make you use telehealth unless there is a declared state of emergency, or a facility is using its' disaster plan.
- Get support and have the tools needed for telehealth.
    - You may need a tablet, laptop, smartphone, or browser to access telehealth services.
    - UHA works with contracted providers to make sure you have access to services based on your ability to use tools needed for telehealth.
    - UHA will help identify what telehealth tool is best for you.

Talk to your provider about telehealth. You can also call Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711. We are open Monday through Friday, 8:00 a.m. to 5:00 p.m.

Prescription medications

To fill a prescription, you can go to any pharmacy in UHA's network. You can find a list of pharmacies we work with in our provider directory at: portal.umpquahealth.com/ClientApp/pharmacies.

For all prescriptions covered by UHA, bring to the pharmacy:

- The prescription.
- Your UHA ID card, Oregon Health ID card or other proof of coverage such as a Medicare Part D ID card or Private Insurance card. You may not be able to fill a prescription without them.

Covered prescriptions

UHA list of covered medications is at: www.umpquahealth.com/pharmacy-services

- If you are not sure if your medication is on our list, call us. We will check for you.

If your medication is not on the list, tell your provider. Your provider can ask us to cover it.

- UHA needs to approve some medication on the list before your pharmacy can fill them. For these medications, your provider will ask us to approve it.

UHA also covers some over the counter (OTC) medications when your provider or pharmacy prescribes them for you. OTC medications are those you would normally buy at a store or pharmacy without a prescription, such as aspirin.

Asking UHA to cover prescriptions

When your provider asks UHA to approve or cover a prescription:

- Doctors and pharmacists at UHA will review the request from your provider.
- We will make a decision within 24 hours.
- If we need more information to make a decision, it can take 72 hours.

If UHA decides to not cover the prescription, you will get a letter from UHA. The letter will explain:

- Your right to appeal the decision
- How to ask for an appeal if you disagree with our decision. The letter will also have a form you can use to ask for an appeal.

Call UHA Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711 if you have questions.

Mail-order pharmacy

UHA has three pharmacies in-network available to all our members that mail some medications to your home address. This is called mail-order pharmacy. If picking up your prescription at a pharmacy is hard for you, mail-order pharmacy may be a good option. Call UHA Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711 to:

- Learn more about mail-order pharmacy and
- Get set up with mail-order pharmacy.

You can also contact the mail-order pharmacies using their information below:

- **BirdiRX (preferred)**
  - Please visit their website at www.birdirx.com/
  - Call at 1-855-247-3479 or (855)-BirdiRx
- **Postal Prescription Services (PPS) (preferred)**
  - Please visit their website at www.ppsrx.com
  - Call at 1-800-552-6694.
- **SortPak Pharmacy**
  - Please visit their website at www.sortpak.com
  - Call 1-877-570-7787

OHP pays for behavioral health medications

UHA does not pay for most medications used to treat behavioral health conditions. Instead OHP pays for them. If you need behavioral health medications:

- UHA and your provider will help you get the medications you need.
- The pharmacy sends your prescription bill directly to OHP. UHA and your provider will help you get the behavioral health medications you need. Talk to your provider if you have questions. You can also call UHA Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711.

Prescription coverage for members with Medicare

UHA and OHP do not cover medications that Medicare Part D covers.

- If you qualify for Medicare Part D but choose not to enroll, you will have to pay for these medications.
- If you have Part D, show your Medicare ID card and your UHA ID card at the pharmacy.
- If Medicare Part D does not cover your medication, your pharmacy can bill UHA. If UHA covers the medication, we will pay for it.

Learn more about Medicare benefits on pages 31 and 92.

Getting prescriptions and vaccines before a trip

If you plan to travel out of state, make sure you have enough medication for your trip. To do this, ask to get a prescription refill early. This is called a vacation override. Please call UHA at 541-229-4842, TTY 541-440-6304 or TTY 711 to find out if this is a good option for you.

Some vaccines needed to travel are covered by UHA. For more information, contact your provider or UHA Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711. You can also look at the online formulary: www.umpquahealth.com/pharmacy-services.

Medication Therapy Management

If you need help filling your medicines or have any questions about them, our Medication Therapy Management program can help. Our UHA Pharmacy Services team wants to make sure your medicines are doing their job. If the pharmacy team or your provider thinks this program can help, we might contact you by phone or mail. If you are concerned about your medicines, you can ask for help too. To sign up, go to www.umpquahealth.com/pharmacy-services/ or call 541-229-7007.

Hospitals

We work with the hospitals below for regular hospital care. You can get emergency care at any hospital.

Mercy Medical Center is your primary hospital:

- Address: 2700 Stewart Parkway
  Roseburg, OR 97471
- Phone number: 541-673-0611, TTY 541-677-2143
- Website: chimercyhealth.com/

If you need a service which they are not able to provide, you will be referred to a different hospital. UHA is also contracted with the following hospital outside of Douglas County:

Sacred Heart Riverbend

- Address: 3333 Riverbend Dr.
  Springfield, OR 97477
- Phone number: 541-667-9351
- Website: www.peacehealth.org/hospitals/sacred-heart-medical-center-riverbend

Urgent care

An urgent problem is serious enough to be treated right away, but it's not serious enough for immediate treatment in the emergency room. These urgent problems could be physical, behavioral or dental.

You can get urgent care services 24 hours a day, 7 days a week without preapproval.
You do not need a referral for urgent or emergency care. For a list of urgent care centers and walk-in clinics see below.

Urgent physical care

Some examples of urgent physical care are:

- Cuts that don't involve much blood but might need stitches.
- Minor broken bones and fractures in fingers and toes.
- Sprains and strains.

If you have an urgent problem, call your primary care provider (PCP). For a list of primary care providers and their phone numbers, visit the Provider Directory here: www.portal.umpquahealth.com/ClientApp/providers. For more information about the Provider Directory, see page 27.

You can call anytime, day or night, on weekends and holidays. Tell the PCP office you are a UHA member. You will get advice or a referral. If you can't reach your PCP about an urgent problem or if your PCP can't see you soon enough, go to an urgent care center or walk-in clinic. You don't need an appointment. See below list of urgent care and walk-in clinics. If you need help, call UHA Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711.

If you don't know if your problem is urgent, still call your provider's office, even if it's closed.
You may get an answering service. Leave a message and say you are a UHA member. You may get advice or a referral of somewhere else to call.

You can also call UHA's 24-Hour Nurse hotline for help anytime of the day or night. This phone number is 888-516-6166 and they will take after hour calls that are urgent or an emergency. If you made a call that is urgent or emergent, you will receive a call back within 30 minutes. If the information provided does not determine it to be urgent, your call will be returned within 60 minutes to gather more information. You or your representative will get a call back as soon as possible for any urgent or emergent calls. If you do not have an emergency and need to contact UHA when we are closed, you can call us at our regular number and leave a message. We will return your call on the next business day.

Urgent care centers and walk-in clinics in the UHA area:

Evergreen Urgent Care Edenbower

- Hours: Monday through Friday from 7:00 am to 7:00 pm, and Saturday and Sunday from 9:00 am to 5:00 pm.
- Phone number: 541-677-7200.
- Address: 2570 NW Edenbower Blvd
  Roseburg OR 97471

Evergreen Urgent Care North

- Hours: 7 days a week, 9:00 am to 5:00 pm
- Phone number: 541-529-4711
- Address: 249 Dakota Street
  Sutherlin, OR 97479

Umpqua Health Newton Creek

- Hours: Monday through Saturday, 7:00 am to 7:00 pm
- Phone number: 541-229-7038
- Address is 3031 NE Stephens St,
  Roseburg OR 97470

Urgent dental care

Some examples of urgent dental care include:

- Tooth pain that wakes you up at night and makes it difficult to chew.
- A chipped or broken tooth.
- A lost crown or filling.
- Abscess (a pocket of pus in a tooth caused by an infection).

If you have an urgent dental problem call your primary care dentist (PCD)
If you cannot reach your PCD or you do not have one, call Advantage Dental Services at 866-268-9631. They will help you find urgent dental care, depending on your condition. You should get an appointment within 2 weeks, or 1 week if you're pregnant, for an urgent dental condition.

Emergency care

Call 911 if you need an ambulance or go to the emergency room when you think you are in danger. An emergency medical condition needs immediate attention and puts your life in danger. It can be a sudden injury or a sudden illness. Emergencies can also cause harm to your body. If you are pregnant, the emergency can also cause harm to your baby. These emergent problems could be physical, behavioral, or dental. All are covered services at no cost to you.

You can get urgent and emergency services 24 hours a day, 7 days a week without preapproval. You don't need a referral.

Physical emergencies

Emergency physical care is for when you need immediate care, and your life is in danger.
Some examples of medical emergencies include:

- Broken bones.
- Bleeding that does not stop.
- Possible heart attack.
- Loss of consciousness.
- Seizure.
- Severe pain.
- Difficulty breathing.
- Allergic reactions.

More information about emergency care:

- Call your PCP or UHA Customer Care within 3 days of receiving emergency care.
- You have a right to use any hospital or other setting, within the United States.
- An emergency is covered in the United States. It is not covered in Mexico or Canada.
- Emergency care provides post stabilization (after care) services. After care services are covered services related to an emergency condition. These services are given to you after you are stabilized. They help to maintain your stabilized condition. They help to improve or fix your condition. For more information, see pages 87-88.

See a list of hospitals with emergency rooms on page 82.

Dental emergencies

A dental emergency is when you need same-day dental care. This care is available 24 hours a day and 7 days a week. A dental emergency may require immediate treatment. Some examples are:

- A tooth has been knocked out (that is not a childhood “wiggly” tooth).
- You have facial swelling or infection in the mouth.
- Bleeding from your gums that won’t stop.

Emergency care is available 24 hours a day, seven days a week. Prior approval is not required for a dental emergency. Call your PCD, if you are unable to reach your PCD, call Advantage Dental Services at 866-268-9631. They can help you find a dentist who will see you. If you are unable to reach your PCD or DCG, call 911 or go to the ER. Tell the ER staff the name of your PCD. See a list of hospitals with emergency rooms on page 82.

Behavioral health crisis and emergencies

A behavioral health emergency is when you need help right away to feel or be safe. It is when you or other people are in danger. An example is feeling out of control. You might feel like your safety is at risk or have thoughts of hurting yourself or others.

Call 911 or go to the emergency room if you are in danger.

- Behavioral health emergency services do not need a referral or preapproval. UHA offers members crisis help and services after an emergency.
- A behavioral health provider can support you in getting services for improving and stabilizing mental health. We will try to help and support you after a crisis.

You can call, text or chat 988. 988 is a Suicide and Crisis lifeline that you can get caring and compassionate support from trained crisis counselors 24 hours a day, 7 days a week.

For culturally & linguistically specific 988 services:

1. Press “1” to reach the Veterans Crisis Line.
2. Press “2” to reach the Language Line (over 240 languages)
3. Press “3” to reach a LGBTQIA+ Trained Counselor

988 SUICIDE & CRISIS LIFELINE

Local and 24-hour crisis numbers, walk-in and drop-off crisis centers:

Adapt Integrated Health Care:
24-hour crisis line: Toll-free: 1-800-866-9780
Provides same-day walk-in access to behavioral health crisis services from 8:00AM – 5:00PM.

Douglas County
24 Hour Crisis Line: 800- 866-9780

Youth & Families:
(541) 229-8934
548 SE Jackson St.
Roseburg, OR 97470

Adults:
(541) 440-3532
621 W. Madrone St.
Roseburg, OR 97470

Coos County
24 Hour Crisis Line: (888) 543-5763
Location: 281 LaClair Street
Coos Bay, OR 97420
Local Crisis Line (541) 266-6800

Adapt Mobile Crisis Services: Mobile Crisis Counselors can respond with 911 and help prevent arrest. If you call 911 for a mental health crisis, request help from mobile crisis. A mental health counselor and case manager will help you de-escalate. They also provide support and other resources.

Suicide Prevention Lifeline
- 1-800-273-TALK (8255)
- 1-888-628-9454 (Spanish)

Teen Support
- oregonyouthline.org/
- Text: teen2teen to 839863

A behavioral health crisis is when someone's behavior becomes a risk to themselves or others. You may need help quickly. If not treated, the condition can become an emergency. Please call one of the 24-hour local crisis lines above or call 988 if you are experiencing any of the following or are unsure if it is a crisis. We want to help and support you in preventing an emergency.

Warning signs: examples of things to look for if you or a family member is having a behavioral health emergency or crisis:

- Talking about wanting to die or kill themselves.
- Talking about feeling hopeless or having no reason to live.
- Increasing use of alcohol or drugs.
- Hearing voices that are telling you to hurt yourself or another person.
- Hurting other people, animals, or property.
- Dangerous or very disruptive behaviors at school, work, or with friends or family.
- Showing rage or talking about seeking revenge.

Here are some things UHA can do to support stabilization in the community:

- A crisis hotline to call when a member needs help
- Mobile crisis team that will come to a member who needs help.
- Walk-in and drop-off crisis centers (see page 86)
- Crisis respite (short-term care)
- Short-term places to stay to get stable
- Post-stabilization services and urgent care services. This care is available 24 hours a day and 7 days a week.
    - Post-stabilization care services are covered services, related to a medical or behavioral health emergency, that are provided after the emergency is stabilized and to maintain stabilization or resolve the condition.
- Crisis response services, 24 hours a day, for members receiving intensive in-home behavioral health treatment.

See more about behavioral health services offered on pages 48-53.

Suicide prevention

You can help prevent suicide. Outreach for help if you, or someone you know, has any of the warning signs listed below. Help is available, speak to someone today. If you need prevention resources, contact UHA.

Common suicide warning signs

Get help if you notice any signs that you or someone you know is thinking about suicide. At least 80% of people thinking about suicide want help. You need to take warning signs seriously.

Here are some suicide warning signs:

- Talking about wanting to die or kill oneself.
- Planning a way to kill oneself, such as buying a gun.
- Feeling hopeless or having no reason to live.
- Feeling trapped or in unbearable pain.
- Talking about being a burden to others.
- Giving away prized possessions.
- Thinking and talking a lot about death.
- Using more alcohol or drugs.
- Acting anxious or agitated.
- Behaving recklessly.
- Withdrawing or feeling isolated.
- Having extreme mood swings.

Never keep thoughts or talk of suicide a secret!

You can also get help by:

- **Dialing 988:** When calling 988, a trained crisis counselor answers the phone, listens to the caller, understands how their problem is affecting them, provides support, and shares resources if needed. If possible, you will be redirected to the local crisis center.
- **Searching for your county mental health crisis number online.** They can provide screenings and help you get the services you need. For a list of additional crisis hotlines, see page 86 or go to adaptoregon.org/services/mental-health-care/crisis-services/.
- **Adult Mental Health Services:** Choice Model Services coordinates care for adults with serious mental illness when they leave the Oregon State Hospital. This program helps discharged members get the community services they need to live. This could be outpatient or residential treatment, adult foster care, or living in a supported apartment. The goal is to avoid going back to the state hospital.
- **Children's Mental Health Services:** Children with behavioral needs are served through Wraparound or intensive care coordination. Intensive care coordination services meet the child and family's needs. System of Care and Wraparound planning involves everyone in the child's life. This includes schools, local programs, doctors, the criminal justice system, and others. This forms a team around the child and family to plan support services.

Follow-up care after an emergency

Follow-up care after an emergency and until your condition is stable is known as post-stabilization services. This includes anything you need after leaving the emergency room. Follow-up care is not

an emergency. OHP does not cover follow-up care when you are out of state. Call your primary care provider or primary care dentist office to set up any follow-up care.

- You must get follow-up care from your regular provider or regular dentist. You can ask the emergency doctor to call your provider to arrange follow-up care.
- Call your provider or dentist as soon as possible after you get urgent or emergency care. Tell your provider or dentist where you were treated and why.
- Your provider or dentist will manage your follow-up care and schedule an appointment if you need one.

If you get emergency care at a hospital that is out-of-network and are needing care after your condition is stable:

- You must return to an in-network provider to get your care covered.
- You must get approval in advance to get your care covered.

Care away from home

Planned care out of state

UHA will help you locate an out of state provider and pay for a covered service when:

- You need a service that is not available in Oregon
- Or if the service is cost effective

To learn more about how you may be able to get a prescription refill before your trip see page 82.

Emergency care away from home

You may need urgent or emergency care when away from home or outside of the UHA service area. **Call 911 or go to any emergency department.** You do not need preapproval for emergency services. Emergency medical services are covered throughout the United States, this includes behavioral health and emergency dental conditions. We do not cover services outside the United States, including Canada and Mexico.

Do not pay for emergency care. If you pay the emergency room bill, UHA is not allowed to pay you back. See page 89 for what to do if you get billed.

Please follow steps below if you need emergency care away from home:

1. Make sure you have your Oregon Health ID Card and UHA ID card with you when you travel out of state.
2. Show them your UHA ID Card and ask them to bill UHA.
3. Do not sign any paperwork until you know the provider will bill UHA. Sometimes UHA cannot pay your bill if an agreement to pay form has been signed. To learn more about this form see pages 90-91.
4. If possible, you can ask that the Emergency Room or provider's billing office to contact UHA if they want to verify your insurance or have any questions.
5. If you need advice on what to do when you need non-emergency care away from home, call UHA for help.

In times of emergency the steps above are not always possible. Being prepared and knowing what steps to take for emergency care out of state may fix billing issues while you are away. These steps may help prevent you being billed for services that UHA can cover. UHA cannot pay for a service if the provider has not sent us a bill.

Bills for services

OHP members do not pay bills for covered services

When you set up your first visit with a provider, tell the office that you are with UHA. Let them know if you have other insurance, too. This will help the provider know who to bill. Take your ID card with you to all medical visits.

No UHA in-network provider (for a list of in-network providers see page 27 or someone working for them can bill a member, send a member's bill to a collection agency, or maintain a civil action against a member to collect any money owed by UHA for services you are not responsible for to the contracted provider.

UHA pays for all covered services in accordance with the Prioritized List of Health Services. For more information about this list, see page 34.

Members cannot be billed for missed appointments or errors.

- Missed appointments are not an OHP (Medicaid) service and are not billable to the member or OHP.
- If your provider does not send the right paperwork or does not get an approval, you cannot get a bill for that. This is called provider error.

Members cannot get balance or surprise billing.

When a provider bills for the amount remaining on the bill that's called balance billing. It is also called surprise billing. The amount is the difference between the actual billed amount and the amount UHA pays. This happens most often when you see an out-of-network provider. Members are not responsible for these costs.

If you have questions, call Customer Care 541-229-4842, TTY 541-440-6304 or TTY 711. People with Medicare and Medicaid already enjoy these protections and are not at risk for surprise billing.

If your provider sends you a bill, do not pay it.

Call UHA for help right away at 541-229-4842, TTY 541-440-6304 or TTY 711. You can also call your provider's billing office and make sure they know you have OHP. If you got a bill because your claim was denied by UHA, contact Customer Care. Learn more about denials, your right to an appeal, and what to do if you disagree with us on pages 102-107. You can also appeal by sending UHA a letter saying that you disagree with the bill because you were on OHP at the time of service.

There may be services you have to pay for

Usually, with UHA, you will not have to pay any medical bills. Sometimes though, you do have to pay. When you need care, talk to your provider about options. The provider's office will check with UHA to see if a treatment or services is not covered. If you chose to get a service that is not covered, you may have to pay the bill.

You have to pay the provider if:

- **You get routine care outside of Oregon.** You get services outside Oregon that are not for urgent or emergency care.
- **You don't tell the provider you have OHP.** You did not tell the provider that you have UHA, another insurance or gave a name that did not match the one on the UHA ID at the time of or after the service was provided, so the provider could not bill UHA. Providers must verify your UHA eligibility at the time of service and before billing or doing collections. They must try to get coverage info prior to billing you.
- **You continue to get a denied service.** You or your representative requested continuation of benefits during an appeal and contested case hearing process, and the final decision was not in your favor. You will have to pay for any charges incurred for the denied services on or after the effective date on the notice of action or notice of appeal resolution.
- **You get money for services from an accident.** If a third-party payer, like car insurance, sent checks to you for services you got from your provider and you did not use these checks to pay the provider.
- **We don't work with that provider.** When you choose to see a provider that is not in-network with UHA you may have to pay for your services. Before you see a provider that is not in-network with UHA you should call Customer Care or work with your PCP. Prior approval may be needed or there may be a provider in-network that can fit your needs. For a list of in-network Providers see page 27.
- **You choose to get services that are not covered.** You have to pay when you choose to have services that the provider tells you are not covered by UHA. In this case:
    - The service is something that your plan does not cover.
    - Before you get the service, you sign a valid Agreement to Pay form. Learn more about the form on the next page.
    - Always contact UHA Customer Care first to discuss what is covered. If you get a bill, please contact UHA Customer Care right away.

Examples of some non-covered services:

- Some treatments, like over the counter medications, for conditions that you can take care of at home or that get better on their own (colds, mild flu, corns, calluses, etc.)
- Cosmetic surgeries or treatments for appearance only.
- Services to help you get pregnant.
- Treatments that are not generally effective.
- Orthodontics, except for handicapping malocclusion and to treat cleft palate in children.

If you have questions about covered or non-covered services, please contact UHA Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711.

You may be asked to sign an Agreement to Pay form

An agreement to pay form (OHP form number 3165 and 3166) is used when you want a service that is not covered by UHA or OHP. The form is also called a waiver. You can see a copy of the form at bit.ly/OHPwaiver.

The following must be true for the Agreement to Pay form to be valid:

- The form must have the estimated cost of the service. This must be the same as on the bill.
- The service is scheduled within 30 days from the date you signed the form.

- The form says that OHP does not cover the service.
- The form says you agree to pay the bill yourself.
- You asked to privately pay for a covered service. If you choose to do this, the provider may bill you if they tell you in advance the following:
    - The service is a covered and UHA would pay them in full for the covered service.
    - The estimated cost, including all related charges, the amount UHA would pay for the service. The provider cannot bill you for an amount more than UHA would pay; and,
    - You knowingly and voluntarily agree to pay for the covered service.
- The provider documents in writing, signed by you or your representative, that they gave you the information above, and:
    - They gave you a chance to ask questions, get more information, and consult with your caseworker or representative.
    - You agree to privately pay. You or your representative sign the agreement that has all the private pay information.
    - The provider must give you a copy of the signed agreement. The provider cannot submit a claim to UHA for the covered service listed on the agreement.

Bills for emergency care away from home or out of state

Because some out of network emergency providers are not familiar with Oregon's OHP (Medicaid) rules, they may bill you. Contact UHA Customer Care if you get a bill. We may have resources to help if you have been wrongfully billed.

Call us right away if you get any bills from out of state providers. Some providers send unpaid bills to collection agencies and may even sue in court to get paid. It is harder to fix the problem once that happens. As soon as you receive a bill for services you got when you were on OHP:

- Do not ignore medical bills.
- Contact UHA Customer Care as soon as possible and tell us a provider is billing you for an OHP service. We will try to help you get the bill cleared up. Do not wait until you get more bills.
    - Follow-up with us to make sure we paid the bill.
- If you get court papers, call us right away. You may also call an attorney or the Public Benefits Hotline at 800-520-5292 for free legal advice. There are consumer laws that can help you when you are wrongfully billed while on OHP.
- If you got a bill because your claim was denied by UHA, contact Customer Care. Learn more about denials, your right to an appeal, and what to do if you disagree with us on pages 102-107.
    - You can also appeal by sending UHA a letter saying that you disagree with the bill because you were on OHP at the time of service.

Important tips about paying for services and bills

- We strongly urge you to call Customer Care before you agree to pay a provider.
- If your provider asks you to pay a copay, do not pay it! Ask the office staff to call UHA.
- UHA pays for all covered services in accordance with the Prioritized List of Health Services, see page 34.
- For a brief list of benefits and services that are covered under your OHP benefits with UHA who also covers case management and care coordination, see pages 62-63. If you have any questions about what is covered, you can ask your PCP or call UHA Customer Care.

- No UHA in-network provider or someone working for them can bill a member, send a member's bill to a collection agency, or maintain a civil action against a member to collect any money owed by UHA for services you are not responsible for.
- Members are never charged for rides to covered appointments. See pages 75-79. Members may ask to get reimbursements for driving to covered visits or get bus passes to use the bus to go to covered visits.
- Protections from being billed usually only apply if the medical provider knew or should have known you had OHP. Also, they only apply to providers who work with OHP (but most providers do).
- Sometimes, your provider does not fill out the paperwork correctly. When this happens, they might not get paid. That does not mean you have to pay. If you already got the service and we refuse to pay your provider, your provider still cannot bill you.
- You may get a notice from us saying that we will not pay for the service. That notice does not mean you have to pay. The provider will write off the charges.
- If UHA or your provider tell you that the service is not covered by OHP, you still have the right to challenge that decision by filing an appeal and asking for a hearing. See pages 102-107.
- In the event of UHA closing, you are not responsible to pay for services we cover or provide.

Members with OHP and Medicare

Some people have OHP (Medicaid) and Medicare at the same time. OHP covers some things that Medicare does not. If you have both, Medicare is your main health coverage. OHP can pay for things like medications that Medicare doesn't cover.

If you have both, you are not responsible for:

- Co-pays
- Deductibles or
- Co-insurance charges for Medicare services, those charges are covered by OHP.

You may need to pay a co-pay for some prescription costs.

There are times you may have to pay deductibles, co-insurance or co-pays if you choose to see a provider outside of the network. Contact your local Aging and People with Disabilities (APD) or Area Agency on Aging (AAA) office. They will help you learn more about how to use your benefits. Call the Aging and Disability Resource Connection (ADRC) at 855-673-2372 to get your local APD or AAA office phone number.

Call Customer Care to learn more about which benefits are paid for by Medicare and OHP (Medicaid), or to get help finding a provider and how to get services.

Providers will bill your Medicare and UHA.
UHA works with Medicare and has an agreement that all claims will be sent so we can pay.

- Give the provider your OHP ID number and tell them you're covered by UHA. If they still say you owe money, call Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711. We can help you.
- Learn about the few times a provider can send you a bill on page 90.

Members with Medicare can change or leave the CCO they use for physical care at any time. However, members with Medicare must use a CCO for dental and behavioral health care.

Changing CCOs and moving care

You have the right to change CCOs or leave a CCO.

If you do not have a CCO, your OHP is called Fee-for-service or open card. This is called “fee-for-service” because the state pays providers a fee for each service they provide. Fee-for-service members get the same types of physical, dental, and behavioral health care benefits as CCO members.

The CCO you have depends on where you live. The rules about changing or leaving a CCO are different when there’s only one CCO in the area and when there are more CCOs in an area.

Member requests to change

There are several chances for you to change, which include but are not limited to the following “without cause” reasons:

- If you do not want the CCO you’ve been assigned to. You can change during the first 90 days after you enroll.
- You may request to change your CCO enrollment within 30 days of an enrollment error
- When you renew your OHP coverage (usually once a year).
- Whenever OHA re-determines your coverage.
- After you have been enrolled in a CCO for six months.
- Once a year, for any reason.
- If you lose OHP for less than 2 months, are reenrolled into a CCO and missed the chance to pick the CCO when you would have renewed your OHP.
- When OHA has set sanctions on UHA, including not allowing new enrollment {42 CFR 438.702(a)(4)}.

You might choose to leave UHA and go to OHP fee-for-service at any time for any of the following “with cause” reasons:

- The CCO has moral or religious objects about the service you want.
- You have a medical reason. When related services are not available in network and your provider says that getting the services separately would mean unnecessary risk. Example: a Caesarean section and a tubal ligation at the same time.
- Other reasons including, but not limited to, poor care, lack of access to covered services, or lack of access to network providers who are experienced in your specific health care needs.
- Services are not provided in your preferred language.
- Services are not provided in a culturally appropriate manner; or
- You’re at risk of having a lack of continued care.
- If you move to a place that your CCO does not serve. To update your address, please inform OHP Customer Services at 800-699-9075 (TTY 711) or Client Services Unit at 800-273-0557. They will confirm whether you need to be placed in a different CCO.

If you move to a place that your CCO does not serve, you can change plans as soon as you tell OHP about the move. Please call OHP at 800-699-9075 or use your online account at ONE.Oregon.gov.

You can ask about these options by phone or in writing. Please call OHP Client Services at 800-273-0557 or email Oregon.Benefits@odhsoha.oregon.gov.

Members with Medicare and OHP (Medicaid)

These members can change or leave the CCO they use for physical care at any time. However, members with Medicare must use a CCO for dental and behavioral health care.

American Indian and Alaska Native with proof of Indian Heritage

These members may want to get care somewhere else. They can get care from an Indian Health Services facility, tribal health clinic/program, or urban clinic and OHP fee-for-service. For more information about these services, see pages 25-26.

How to change or leave your CCO

Things to consider: UHA wants to make sure you receive the best possible care. UHA can give you some services that FFS or open card cannot. When you have a problem getting the right care, please let us try to help you before leaving UHA.

If you still wish to leave, there must be another CCO available in your service area for you to switch your plan.

Tell OHP if you want to change or leave your CCO. You must make this request orally or in writing. You and/or your representative can call OHP Customer Care at 800-699-9075 or 800-273-0557 (TTY 711) from Monday through Friday, 8 a.m. to 5 p.m. PT. Use your online account at ONE.Oregon.gov or email OHP at Oregon.Benefits@odhsoha.oregon.gov. The effective date of the disenrollment will be the first day of the month following OHA approval of the disenrollment.

You can get care while you change your CCO. See pages 93-96 to learn more.

UHA can ask you to leave for some reasons:

UHA may ask OHA to remove you from our plan if you:

- Are abusive, uncooperative, or disruptive to our staff or providers. Unless when the behavior is due to your special health care need or disability.
- Commit fraud or other illegal acts, such as letting someone else use your health care benefits, changing a prescription, theft, or other criminal acts.
- Are violent or threat violence. This could be directed at a health care provider, their staff, other patients, or UHA staff. When the act or threat of violence seriously impairs UHA ability to furnish services to either you or other members.

We have to ask the state (Oregon Health Authority) to review and approve removing you from our plan. You will get a letter if the CCO ask to disenroll (remove) you has been approved. You can make a complaint if you are not happy with the process or if you disagree with the decision. See pages 101-107 for how to make a complaint or ask for an appeal.

UHA cannot ask to remove you from our plan because of reasons related to (but not limited to):

- Your health status gets worse.
- You don't use services.
- You use many services.

- You are about to use services or be placed in a care facility (like a long-term care facility or Psychiatric Residential Treatment Facility)
- Special needs behavior that may be disruptive or uncooperative.
- Your protected class, medical condition or history means you will probably need many future services or expensive future services.
- Your physical, intellectual, developmental, or mental disability.
- You are in the custody of ODHS Child Welfare.
- You make a complaint, disagree with a decision, ask for an appeal or hearing.
- You make a decision about your care that UHA disagrees with.

For more information or questions about other reasons you may be disenrolled, temporary enrollment exceptions or enrollment exemptions, call UHA at 541-229-4842, TTY 541-440-6304 or TTY 711 or OHP Client Services at 800-273-0557.

You will get a letter with your disenrollment rights at least 60 days before you need to renew your OHP.

Care while you change or leave a CCO

Some members who change plans might still get the same services, prescription drug coverage and see the same providers even if not in-network. That means care will be coordinated when you switch CCOs or move from OHP fee-for-service to a CCO. This is sometimes called “Transition of Care.”

If you have serious health issues, need hospital care or inpatient mental health care, your new and old plans must work together to make sure you get the care and services you need.

When you need the same care while changing plans

This help is for when you have serious health issues, need hospital care, or inpatient mental health care. Here is a list of some examples of when you can get this help:

- You need end-stage renal disease care.
- You’re a medically fragile child.
- You are receiving breast and/or cervical cancer treatment program members.
- You are receiving Care Assist help due to HIV/AIDS.
- You need post-transplant care.
- You’re pregnant or just had a baby.
- You are receiving treatment for cancer.
- Any member that if they don’t get continued services may suffer serious detriment to their health or be at risk for the need of hospital or institution care.

The timeframe that this care lasts is:

Membership Type	How long you can get the same care
OHP with Medicare (Full Benefit Dual Eligible)	90 days
OHP only	30 days for physical and oral health* 60 days for behavioral health*

*Or until your new primary care provider (PCP) has reviewed your treatment plan.

If you are leaving UHA, we will work with your new CCO or OHP to make sure you can get those same services listed below.

If you need care while you change plans or have questions, please call UHA Customer Care at: 541-229-4842, TTY 541-440-6304 or TTY 711. Hours: Monday through Friday, 8:00 a.m. to 5:00 p.m.

UHA will make sure members who need the same care while changing plans get:

- Continued access to care and rides to care.
- Services from their provider even if they are not in the UHA network until one of these happen:
  - The minimum or approved prescribed treatment course is completed, or
  - Your provider decides your treatment is no longer needed. If the care is by a specialist, the treatment plan will be reviewed by a qualified provider.
- Some types of care will continue until complete with the current provider. These types of care are:
  - Care before and after you are pregnant/deliver a baby (prenatal and postpartum).
  - Transplant services until the first-year post-transplant.
  - Radiation or chemotherapy (cancer treatment) for their course of treatment.
  - Medications with a defined least course of treatment that is more than the transition of care timeframes above.

You can get a copy of the UHA Transition of Care Policy by calling Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711. It is also on our website at www.umpquahealth.com/services/#notices-policies. Please call Customer Care if you have questions.

End of life decisions

Advance directives

All adults have the right to make decisions about their care. This includes the right to accept and refuse treatment. An illness or injury may keep you from telling your doctor, family members or representative about the care you want to receive. Oregon law allows you to state your wishes, beliefs, and goals in advance, before you need that kind of care. The form you use is called an **advance directive**. You have the right to create an advance directive.

If you need more information regarding UHA's policies and procedures about Advance Directives, go online: www.umpquahealth.com/services/#notices-policies and read our CE09 – Advance Directive/Declaration of Mental Health Treatment policy.

An advance directive allows you to:

- Share your values, beliefs, goals and wishes for health care if you are unable to express them yourself.
- Name a person to make your health care decisions if you could not make them for yourself. This person is called your health care representative and they must agree to act in this role.
- The right to share, deny or accept types of medical care and the right to share your decisions about your future medical care.

How to get more information about Advance Directives

We can give you a free brochure on advance directives. Just call us to learn more, get a copy of the brochure and the Advance Directive form. Call UHA Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711. UHA has also partnered with Iris Healthcare to provide Advance Care Planning. For more information about Iris, see pages 98-99.

An Advance Directive User's Guide is available. It provides information on:

- The reasons for an Advance Directive.
- The sections in the Advance Directive form.
- How to complete or get help with completing an Advance Directive.
- Who should be provided a copy of an Advance Directive.
- How to make changes to an Advance Directive.

To download a copy of the Advance Directive User's Guide or the Advance Directive form, please visit: www.oregon.gov/oha/ph/about/pages/adac-forms.aspx. You can also contact UHA Customer Care and request a hard copy be mailed at no cost to you.

Other helpful information about Advance Directives

- Completing the advance directive is your choice. If you choose not to fill out and sign the advance directive, your coverage or access to care will stay the same.
- You will not be treated differently by UHA if you decide not to fill out and sign an advance directive.
- If you complete an advance directive be sure to talk to your providers and your family about it and give them copies.
- UHA will honor any choices you have listed in your completed and signed Advance Directive.

How to complain if UHA did not follow advance directive requirements

You can make a complaint to the Health Licensing Office if your provider does not do what you ask in your advance directive.

Health Licensing Office

- Phone: 503-370-9216 (TTY users, please call 711)
- Hours: Monday through Friday, 8 a.m. to 5 p.m. PT
- Mail a complaint to:
  1430 Tandem Ave NE, Suite 180
  Salem, OR 97301
- Email: hlo.info@odhsoha.oregon.gov

Call UHA Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711 to get a paper copy of the complaint form. You can find also find complaint forms and learn more at: www.oregon.gov/oha/PH/HLO/Pages/File-Complaint.aspx.

UHA follows the State and Federal laws regarding Advance Directives. Oregon law allows UHA or any provider to object to following it as a matter of conscience. Also, we are not required to provide any care the conflicts with the Advanced Directive. UHA does not have any conscience objections. If you have an Advance Directive, you should talk to your provider about it to make sure they do not

have any conscience objections.

How to Cancel an Advance Directive

To cancel, ask for copies of your advance directive back so your provider knows it is no longer valid. Tear them up or write CANCELED in large letters, sign, and date them. For questions or more info contact Oregon Health Decisions at 800-422-4805 or 503-692-0894 (TTY 711).

What is the difference between a POLST and advance directive?

Portable Orders for Life-Sustaining Treatment (POLST)

A POLST is a medical form that you can use to make sure your wishes for treatment near the end of life are followed by medical providers. You are never required to fill out a POLST, but if you have serious illnesses or other reasons why you would not want all types of medical treatment, you can learn more about this form. The POLST is different from an Advance Directive:

	Advance Directive	POLST
What is it?	Legal document	Medical order
Who should get it?	For all adults over the age of 18	People with a serious illness or are older and frail and might not want all treatments
Does my provider need to approve/sign?	Does not require provider approval	Needs to be signed and approved by healthcare provider
When is it used?	Future care or condition	Current care and condition

To learn more, visit: https://oregonpolst.org/, email: polst@ohsu.edu, or call Oregon POLST at 503-494-3965.

Iris Healthcare (Advance Care Planning)

Do you need help creating an Advance Care Plan? Iris is our partner for providing Advance Care Planning. They provide help to members dealing with serious illness. Their health experts help members talk to their loved ones or care givers to create a plan for member's care.

Iris Empower is a free Advance Care planning tool for people in Douglas County. Empower is a way to make care plans online. It helps users with:

- Making healthcare choices
- Making advance directives
- Sharing plans with family members
- Sharing plans with care teams

If you would like to make an advance care plan:

- Follow the link on UHA's website: www.umpquahealth.com/advanced-care-planning/
- Contact UHA Customer Care

If you would like to contact Iris Health Care:

- Phone: 512-895-9544 or Toll-Free 1-800-845-2081
- Email: getinfo@irishealthcare.com
- Online: www.irishealthcare.com

Declaration for Mental Health Treatment

Oregon has a form for writing down your wishes for mental healthcare. The form is called the Declaration for Mental Health Treatment. The form is for when you have a mental health crisis, or you can't make decisions about your mental health treatment. You have the choice to complete this form, when not in a crisis, and can understand and make decisions about your care.

What does this form do for me?

The form tells what kind of care you want if you are ever unable to make decisions on your own. Only a court and two doctors can decide if you cannot make decisions about your mental health.

This form allows you to make choices about the kinds of care you want and do not want. It can be used to name an adult to make decisions about your care. The person you name must agree to speak for you and follow your wishes. If your wishes are not in writing, this person will decide what you would want.

A declaration form is only good for 3 years. If you become unable to decide during those 3 years, your form will take effect. It will remain in effect until you can make decisions again. You may cancel your declaration when you can make choices about your care. You must give your form both to your PCP and to the person you name to make decisions for you.

To learn more about the Declaration for Mental Health Treatment, visit the State of Oregon's website at https://aix-xweb1p.state.or.us/es_xweb/DHSforms/Served/le9550.pdf.
If your provider does not follow your wishes in your form, you can complain. A form for this is at www.healthoregon.org/hcrqi. Send your complaint to:

Health Care Regulation and Quality Improvement

- Email: Mailbox.HCLC@odhsoha.oregon.gov
- Phone: 971-673-0540 (TTY: 971-673-0372)
- Mail: 800 N.E. Oregon St., #465
  Portland, OR 97232
- Fax: 971-673-0556

Reporting Fraud, Waste, and Abuse

We're a community health plan, and we want to make sure that healthcare dollars are spent helping our members be healthy and well. We need your help to do that.

Medicaid Fraud is against the law and UHA takes this seriously.

Some examples of fraud, waste and abuse by a provider are:

- A provider charging you for a service covered by UHA.
- A provider billing for services that you did not receive.
- A provider giving you a service that you do not need based on your health condition.

Some examples of fraud, waste and abuse by a member are:

- Going to multiple doctors for prescriptions for a drug already prescribed to you.
- Someone using another person's ID to get benefits.

UHA is committed to preventing fraud, waste, and abuse. We will follow all related laws, including the State's False Claims Act and the Federal False Claims Act.

How to make a report of fraud, waste, and abuse

If you think fraud, waste, or abuse has happened, report it as soon as you can. You can report it anonymously. Whistleblower laws protect people who report fraud, waste, and abuse. You will not lose your coverage if you make a report. It is illegal to harass, threaten, or discriminate against someone who reports fraud, waste, or abuse. You can make a report of fraud, waste, and abuse a few ways:

Call, fax, submit on-line or write directly to UHA. **We report all suspected fraud, waste, and abuse committed by providers or members to the state agencies listed below.**

- Call our hotline: Toll-free: 844-348-4702 (TTY 711)
- Fax: 541-229-9982
- Submit a report online: www.umpquahealth.ethicspoint.com
- Write to**:** Compliance Officer
  Umpqua Health Alliance
  3031 NE Stephens St
  Roseburg, OR 97470

Report Member fraud, waste, and abuse by calling, faxing, or writing to:

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

Report Provider fraud, waste, and abuse by calling, faxing, or writing to:

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

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

To report fraud online: www.oregon.gov/dhs/abuse/Pages/fraud-reporting.aspx.

Complaints (Grievances), Appeals and Fair Hearings

UHA makes sure all members have access to a grievance system (complaints, grievances, appeals and hearings). We try to make it easy for members to file a complaint, grievance, or appeal and get info on how to file a hearing with the Oregon Health Authority. The table below tells you how to reach us. We have copies of our forms in our administrative offices. You can also get them from our website or ask for them to be sent to you by email, mail, or by phone.

Let us know if you need help with any part of the complaint (grievance) appeal, and/or hearings process. We can also give you more information about how we handle complaints (grievances) and appeals. Copies of our notice template are also available. If you need help or would like more information beyond what is in the handbook contact us at:

Call our Customer Care team	Write or email
Monday – Friday, 8:00AM – 5:00PM Phone: 541-229-4842 Toll free: 866-672-1551 TTY: 541-440-6304 or TTY 711 Website: www.umpquahealth.com/appeals-and-grievances/	Umpqua Health Alliance Attn: Grievance and Appeals 3031 NE Stephens St Roseburg, OR 97470 UHAGrievance@umpquahealth.com

We will provide you with help to complete forms and other steps needed to file a grievance (complaint), appeal, or hearing. This could be:

- Help from a qualified community health worker (i.e., peer specialist or personal navigator) or care coordination services.
- Interpreter services or auxiliary (added help or support) aids and services.
- A letter in a different language or format.
- Explaining the grievance (complaint), appeals, and hearings process or providing policies or documents.

You can make a complaint

- A **complaint** is letting us know you are not satisfied.
- A **dispute** is when you do not agree with UHA or a provider.
- A **grievance** is a complaint you can make if you are not happy with UHA, your healthcare services, or your provider. A dispute can also be a grievance.

To make it easy, OHP uses the word **complaint** for grievances and disputes, too.

You have a right to make a complaint if you are not satisfied with any part of your care. We will try to make things better. Just call Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711. You can also make a complaint with OHA or Ombuds. You can reach OHA at 1-800-273-0557 or Ombuds at 1-877-642-0450. You can also send us your complaint in the mail:

Umpqua Health Alliance
Attn: Grievance and Appeals
3031 NE Stephens St
Roseburg, OR 97470

You may also find a complaint form at www.umpquahealth.com/appeals-and-grievances/. You can file a complaint about any matter other than a denial for service or benefits and at any time orally or in writing. If you file a complaint with OHA, it will be forwarded to UHA.

Examples of reasons you may file a complaint are:

- Problems making appointments or getting a ride.
- Problems finding a provider near where you live.
- Not feeling respected or understood by providers, provider staff, drivers or UHA
- Care you were not sure about but got anyway.
- Bills for services you did not agree to pay.
- Disputes on UHA extension proposals to make approval decisions.
- Driver or vehicle safety
- Quality of the service you received

A representative or your provider may make (file) a complaint on your behalf, with your written permission to do so.

We will look into your complaint and let you know what can be done as quickly as your health requires. This will be done within 5 business days from the day we got your complaint.

If we need more time, we will send you a letter within 5 business days. We will tell you why we need more time. We will only ask for more time if it's in your best interest. All letters will be written in your preferred language. We will send you a letter within 30 days of when we got the complaint explaining how we will handle it.

If you are unhappy with how we handled your complaint, you can share that with OHP Client Services Unit at 1-800-273-0557 or please reach out to the OHA Ombuds Program. The Ombuds are advocates for OHP members and they will do their best to help you. Please email OHA.OmbudsOffice@odhsoha.oregon.gov or leave a message at 877-642-0450.

Another resource for supports and services in your community is 211 Info. Call 2-1-1 or go to the www.211info.org website for help.

UHA, its contractors, subcontractors, and participating providers cannot:

- Stop a member from using any part of the complaint and appeal system process or take punitive action against a provider who ask for an expedited result or supports a member's appeal.
- Encourage the withdrawal of a complaint, appeal, or hearing already filed; or
- Use the filing or result of a complaint, appeal, or hearing as a reason to react against a member or to request member disenrollment.

You can ask us to change a decision we made about a service. This is called an appeal.

You can call, write a letter or fill out a form that explains why the plan should change its decision.

If we deny, stop, or reduce a medical, dental, or behavioral health service, we will send you a denial letter that tells you about our decision. This denial letter is also called a Notice of Adverse Benefit Determination (NOABD). We will also let your provider know about our decision.

If you disagree with our decision, you have the right to ask us to change it. This is called an appeal because you are appealing our decision. You must get a denial letter before you can ask for an appeal. If you did not receive a letter, or your provider says you cannot have a service or that you will have to pay for a service, you can ask UHA for a denial letter (NOABD). Once you have the denial letter, you can ask for an appeal.

To support your appeal, you have the right to:

- Give information and testimony in person or in writing.
- Make legal and factual arguments in person or in writing.

You must do these things within appeal timeframes on the next page.

Don't agree with our decision? Follow these steps:

1	**Ask for an appeal** You must ask within 60 days of your denial letter's date. Call or send a form.
2	**Wait for our reply** We have 16 days to reply. Need a faster reply? Ask for a fast appeal.
3	**Read our decision** Still don't agree? You can ask the state to review. This is called a hearing.
4	**Ask for a hearing** You must ask within 120 days of the appeal decision letter date.

Learn more about the steps to ask for an appeal or hearing

Step 1 — Ask for an appeal.

You must ask within 60 days of the date of the denial letter (NOABD).

Call us at 541-229-4842, TTY 541-440-6304 or TTY 711 or use the Request to Review a Health Care Decision form. The form will be sent with the denial letter. You can also get it at bit.ly/request2review.

You can mail the form or written request to

Umpqua Health Alliance
Attn: Grievance and Appeals
3031 NE Stephens St
Roseburg, OR 97470

You can also fax the form or written request to 541-677-5881. If you have questions, you can email us at UHAGrievance@umpquahealth.com.

Who can ask for an appeal?
You or someone with written permission to speak for you. That could be your doctor or an authorized representative.

Step 2 — Wait for our reply.

Once we get your request, we will look at the original decision. A new doctor will look at your medical records and the service request to see if we followed the rules correctly. You can give us any more information you think would help us review the decision.

How long do you get to review my appeal?
We have 16 days to review your request and reply. If we need more time, we will send you a letter. We have up to 14 more days to reply.

What if I need a faster reply?
You can ask for a fast appeal. This is also called an expedited appeal. Call us or fax the request form. The form will be sent with the denial letter. You can also get it at bit.ly/request2review. Ask for a fast appeal if waiting for the regular appeal could put your life, health, or ability to function in danger. We will call you and send you a letter, within 1 business day, to let you know we have received your request for a fast appeal.

How long does a fast appeal take?
If you get a fast appeal, we will make our decision as quickly as your health requires, no more than 72 hours from when the fast appeal request was received. We will do our best to reach you and your provider by phone to let you know our decision. You will also get a letter.

At your request or if we need more time, we may extend the timeframe for up to 14 days.

	If a fast appeal is denied or more time is needed, we will call you and you will receive written notice within two days. A denied fast appeal request will become a standard appeal and needs to be resolved in 16 days or possibly be extended 14 more days. If you don't agree with a decision to extend the appeal time frame or if a fast appeal is denied, you have the right to file a complaint.
Step 3	**Read our decision.** We will send you a letter with our appeal decision. This appeal decision letter is also called a Notice of Appeal Resolution (NOAR). If you agree with the decision, you do not have to do anything.
Step 4	**Still don't agree? Ask for a hearing.** You can ask the state to review the appeal decision. This is called asking for a hearing. You must ask for a hearing within 120 days of the date of the appeal decision letter (NOAR). **What if I need a faster hearing?** You can ask for a fast hearing. This is also called an expedited hearing. Use the online hearing form at bit.ly/ohp-hearing-form to ask for a normal hearing or a faster hearing. You can also call the state at 800-273-0557 (TTY 711) or use the request form that will be sent with the letter. Get the form at bit.ly/request2review. You can send the form to: OHA Medical Hearings 500 Summer St NE E49 Salem, OR 97301 Fax: 503-945-6035 The state will decide if you can have a fast hearing 2 working days after getting your request. **Who can ask for a hearing?** You or someone with written permission to speak for you. That could be your doctor or an authorized representative. **What happens at a hearing?** At the hearing, you can tell the Oregon Administrative Law judge why you do not agree with our decision about your appeal. The judge will make the final decision.

Questions and answers about appeals and hearings

What if I don't get a denial letter? Can I still ask for an appeal?

You have to get a denial letter before you can ask for an appeal.

If your provider says that you cannot have a service or that you will have to pay for a service, you can ask us for a denial letter (NOABD). Once you have the denial letter, you can ask for an appeal.

What if UHA doesn't meet the appeal timeline?

If we take longer than 30 days to reply, you can ask the state for a review. This is called a hearing. To ask for a hearing, call the state at 800-273-0557 (TTY 711) or use the request form that will be sent with the denial letter (NOABD). Get the form at bit.ly/request2review.

Can someone else represent me or help me in a hearing?

You have the right to have another person of your choosing represent you in the hearing. This could be anyone, like a friend, family member, lawyer, or your provider. You also have the right to represent yourself if you choose. If you hire a lawyer, you must pay their fees.

For advice and possible no-cost representation, call the Public Benefits Hotline at 1-800-520-5292; TTY 711. The hotline is a partnership between Legal Aid of Oregon and the Oregon Law Center. Information about free legal help can also be found at OregonLawHelp.com.

Can I still get the benefit or service while I'm waiting for a decision?

If you have been getting the benefit or service that was denied and we stopped providing it, you can ask us to continue it.

You need to:

- Ask for this within 10 days of the date of the denial letter (NOABD) or NOAR by the date this decision is effective, whichever is later.
    - You can ask for continued benefits in writing or orally by calling UHA Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711.
- Use the Request to Review a Health Care Decision form. The form will be sent with the denial letter. You can also get it at bit.ly/request2review.
- Answer "yes" to the question about continuing services on box 8 on page 4 on the *Request to Review a Health Care Decision* form.

Do I have to pay for the continued service?

If you choose to still get the denied benefit or service, you may have to pay for it. If we change our decision during the appeal, or if the judge agrees with you at the hearing, you will not have to pay.

If we change our decision and you were not receiving the service or benefit, we will approve or provide the service or benefit as quickly as your health requires. We will take no more than 72 hours from the day we get notice that our decision was reversed.

What if I also have Medicare? Do I have more appeal rights?
If you have both UHA and Medicare, you may have more appeal rights than those listed above. Call Customer Care at 541-229-4842, TTY 541-440-6304 or TTY 711 for more information. You can also call Medicare at 800-633-4227 to find out more on your appeal rights.
What if I want to see the records that were used to make the decision about my service(s)?
You can contact UHA at 541-229-4842, TTY 541-440-6304 or TTY 711 to ask for free copies of all paperwork used to make the decision.

Words to Know

Appeal – When you ask your plan to change a decision you disagree with about a service your doctor ordered. You can call, write a letter or fill out a form that explains why the plan should change its decision. This is called filing an appeal.

Advance Directive – A legal form that lets you express your wishes for end-of-life care. You can choose someone to make health care decisions for you if you can't make them yourself.

Assessment – Review of information about a patient's care, health care problems, and needs. This is used to know if care needs to change and plan future care.

Balance bill (surprise billing) – Balance billing is when you get a bill from your provider for a leftover amount. This happens when a plan does not cover the entire cost of a service. This is also called a surprise bill. OHP providers are not supposed to balance bill members.

Behavioral health – This is mental health, mental illness, addiction, and substance use disorders. It can change your mood, thinking, or how you act.

Copay or Copayment – An amount of money that a person must pay for services like prescriptions or visits. OHP members do not have copays. Private health insurance and Medicare sometimes have copays.

Care Coordination – A service that gives you education, support, and community resources. It helps you work on your health and find your way in the health care system.

Civil Action – A lawsuit filed to get payment. This is not a lawsuit for a crime. Some examples are personal injury, bill collection, medical malpractice, and fraud.

Co-insurance – The amount someone must pay to a health plan for care. It is often a percentage of the cost, like 20%. Insurance pays the rest.

Consumer Laws – Rules and laws meant to protect people and stop dishonest business practices.

Coordinated Care Organization (CCO) – A CCO is a local OHP plan that helps you use your benefits. CCOs are made up of all types of health care providers in a community. They work together to care for OHP members in an area or region of the state.

Crisis – A time of difficulty, trouble, or danger. It can lead to an emergency situation if not addressed.

Declaration of Mental Health Treatment – A form you can fill out when you have a mental health crisis and can't make decisions about your care. It outlines choices about the care you want and do not want. It also lets you name an adult who can make decisions about your care.

Deductible – The amount you pay for covered health care services before your insurance pays the rest. This is only for Medicare and private health insurance.

Devices for habilitation and rehabilitation – Supplies to help you with therapy services or other everyday tasks. Examples include:

- Walkers
- Canes
- Crutches
- Glucose monitors
- Infusion pumps
- Prosthetics and orthotics
- Low vision aids
- Communication devices
- Motorized wheelchairs
- Assistive breathing machine

Diagnosis – When a provider finds out the problem, condition, or disease.

Durable medical equipment (DME) – Things like wheelchairs, walkers and hospital beds that last a long time. They don't get used up like medical supplies.

Emergency dental condition – A dental health problem based on your symptoms. Examples are severe tooth pain or swelling.

Emergency medical condition – An illness or injury that needs care right away. This can be bleeding that won't stop, severe pain or broken bones. It can be something that will cause some part of your body to stop working. An emergency mental health condition is the feeling of being out of control or feeling like you might hurt yourself or someone else.

Emergency medical transportation – Using an ambulance or Life Flight to get medical care. Emergency medical technicians give care during the ride or flight.

ER or ED – It means emergency room or emergency department. This is the place in a hospital where you can get care for a medical or mental health emergency.

Emergency room care – Care you get when you have a serious medical issue and it is not safe to wait. This can happen in an ER.

Emergency services – Care that improves or stabilizes sudden serious medical or mental health conditions.

Excluded services – What a health plan does not pay for. Example: OHP doesn't pay for services to improve your looks, like cosmetic surgery or things that get better on their own, like a cold.

Federal and State False Claims Act – Laws that makes it a crime for someone to knowingly make a false record or file a false claim for health care.

Grievance – A formal complaint you can make if you are not happy with your CCO, your healthcare services, or your provider. OHP calls this a complaint. The law says CCOs must respond to each complaint.

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

Health insurance – A program that pays for healthcare. After you sign up, a company or government agency pays for covered health services. Some insurance programs need monthly payments, called *premiums*.

Home Health Care – Services you get at home to help you live better after surgery, an illness or injury. Help with medications, meals and bathing are some of these services.

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

Hospital inpatient and outpatient care – Inpatient: When you are admitted to a hospital and stay at least three (3) nights. Outpatient: When surgery or treatment is performed in a hospital and then you leave after.

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

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

Medically necessary – Services and supplies that are needed to prevent, diagnose, or treat a medical condition or its symptoms. It can also mean services that are standard treatment.

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

Network – The medical, mental health, dental, pharmacy and equipment providers that have a contract with a CCO.

In-Network or Participating Provider – Any provider that works with your CCO. You can see in-network providers for free. Some network specialists require a referral.

Out-of-Network Provider – A provider who has not signed a contract with the CCO. The CCO doesn't pay for members to see them. You have to get approval to see an out-of-network provider.

OHP Agreement to Pay (OHP 3165 or 3166) Wavier - A form that you sign if you agree to pay for a service that OHP does not pay for. It is only good for the exact service and dates listed on the form. You can see the blank waiver form at bit.ly/OHPwaiver. Unsure if you signed a waiver form? You can ask your provider's office. For additional languages, please visit: www.oregon.gov/oha/hsd/ohp/pages/forms.aspx

Physician services – Services that you get from a doctor.

Plan – A health organization or CCO that pays for its members' health care services.

POLST – **Portable Orders for Life-Sustaining Treatment (POLST).** A form that you can use to make sure your care wishes near the end of life are followed by medical providers.

Post-Stabilization Services – Services after an emergency to help keep you stable, or to improve or fix your condition.

Preapproval (prior authorization, or PA) – A document that says your plan will pay for a service. Some plans and services require a PA before you get the service. Doctors usually take care of this.

Premium – The cost of insurance.

Prescription drug coverage – Health insurance or plan that helps pay for medications.

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

Preventive care or prevention – Health care that helps keep you well. Examples are getting a flu vaccine or a check-up each year.

Primary care provider (PCP) – A medical professional who takes care of your health. They are usually the first person you call when you have health issues or need care. Your PCP can be a doctor, nurse practitioner, physician's assistant, osteopath or sometimes a naturopath.

Primary care dentist (PCD) – The dentist you usually go to who takes care of your teeth and gums.

Provider – Any person or agency that provides a health care service.

Referral – A referral is a written order from your provider noting the need for a service. You must ask a provider for a referral.

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

Representative – A person chosen to act or speak on your behalf.

Screening – A survey or exam to check for health conditions and care needs.

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

Specialist – A medical provider who has special training to care for a certain part of the body or type of illness.

Suicide – The act of taking one's own life.

Telehealth – Video care or care over the phone instead of in a provider's office.

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

Traditional health worker (THW) – A public health worker who works with healthcare providers to serve a community or clinic. A THW makes sure members are treated fairly. Not all THWs are certified by the state of Oregon. There are six (6) different types of THWs, including:

- Community health worker
- Peer wellness specialist
- Personal health navigator
- Peer support specialist
- Birth doula
- Tribal Traditional Health Workers

Urgent care – Care that you need the same day for serious pain. It also includes care to keep an injury or illness from getting much worse or to avoid losing function in part of your body.

Whistleblower – Someone who reports waste, fraud, abuse, corruption, or dangers to public health and safety

UHA Customer Care: 541-229-4UHA (541-229-4842) | Toll Free 866-672-1551
TTY 711 or TTY 541-440-6304
UHCustomerCare@umpquahealth.com
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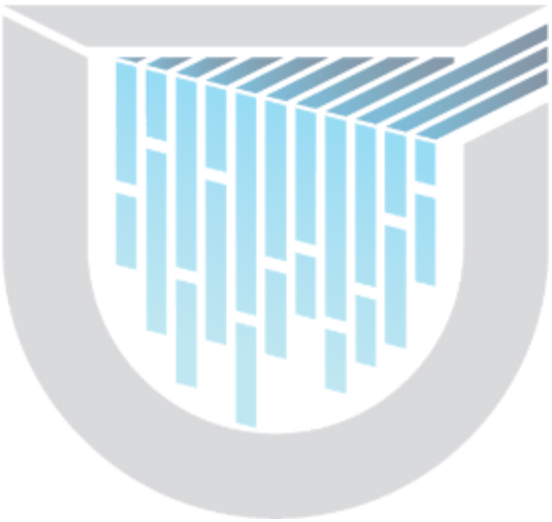
3031 NE Stephens St. Roseburg, OR 97470



UHA's mission works to achieve health equity for all population groups by allocating resources towards designing policies and programs to create greater social justice in health.