InterCommunity Health Network CCO

Member Handbook

Your health benefits as a member of the Oregon Health Plan and IHN-CCO

Updated Jan. 1, 2024

2024

Handbook updates

IHN-CCO 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 **IHNtogether.org/Handbook2024**. If you need help or have questions, call Customer Service at **541-768-4550** (TTY **800-735-2900**).

Getting started

You will be receiving a survey in the mail that will help IHN-CCO know how to support you with your physical, behavioral and oral health care needs. This survey is called a "Survey About Your Health". To learn more about this survey, see the section "Survey About Your Health".

Complete and return your survey in any of these ways:

- Phone: **541-768-4550**, toll free **800-832-4580** (TTY **800-735-2900**)
- Fax: 541-768-6701
- Mail: IHN-CCO
  PO Box 1310
  Corvallis, OR 97339

Helpful tips

Some questions have been answered or can be asked here **Oregon.gov/oha/hsd/ohp/pages/client-questions.aspx**

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

- Always carry your OHP and IHN-CCO member ID cards with you.
  - Note: These will come separately. You will receive your OHP ID card before your IHN-CCO member ID card.

Your IHN-CCO ID card will be mailed to you. You may have already received it or you may receive it in a few days. Each family member signed up for our plan will get their own card. Your ID card has the following information:

- Your name.
- Your member ID number.
- Your Plan information.
- Your primary care provider name and information.
- Customer service phone number.
- Language access phone number.

Fill in your provider information below for easy reference.

- 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 ride to care) is _____
  - Their number is _____

Free help in other languages and formats.

Everyone has a right to know about IHN-CCO'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 **IHNtogether.org/Handbook2024**. If you need help or have questions, call Customer Service Monday through Friday: 8 a.m. to 8 p.m. at **541-768-4550**, toll free **800-832-4580** (TTY **800-735-2900**).

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 five 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. Send a secure message through your MyHealthPlan member portal at **MyHealthPlan.samhealth.org**. Please let us know which documents you would like emailed to you. You can also call Customer Service at **541-768-4550** (TTY **800-735-2900**).

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 an interpreter, please call us at **541-768-4550** (TTY **800-735-2900**) or call OHP Client Services at **800-273-0557** (TTY **711**). See section "Complaint, Appeal and Hearing Rights."

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**.

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 **800-832-4580** or TTY **800-735-2900**. 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 **800-832-4580** o TTY **800-735-2900**. 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. **800-832-4580** или TTY **800-735-2900**. 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 **800-832-4580** hoặc TTY (Đường dây Dành cho Người Khiếm thính hoặc Khuyết tật về Phát âm) **800-735-2900**. 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 **800-832-4580** أو المبرقة الكاتبة**800-735-2900**. 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 **800-832-4580** ama TTY **800-735-2900**. 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 **800-832-4580 或** TTY **800-735-2900**。**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 **800-832-4580** 或聽障專線 **800-735-2900**。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. **800-832-4580** 또는 TTY **800-735-2900** 에 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 **800-832-4580** los sis TTY **800-735-2900**. 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 eṃṃanļọk ippaṃ. Kwomaroñ kajjitōk bwe juon ri ukōt en jipañ eok. Ejjeļọk wōṇāān jipañ in. Kaaltok **800-832-4580** ak TTY **800-735-2900**. 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 **800-832-4580** ika TTY **800-735-2900**. Kich mi etiwa ekkewe keken relay. - 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 **800-832-4580** o TTY **800-735-2900**. Tumatanggap kami ng mga relay na tawag. - 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 **800-832-4580** oder per Schreibtelefon an **800-735-2900.**Wir nehmen Relaisanrufe an. - 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 **800-832-4580**

ou use o serviço TTY **800-735-2900.** 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。**800-832-4580** または TTY **800-735-2900** 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 **800-832-4580** або телетайпу **800-735-2900**Ми приймаємо всі дзвінки, які на нас переводять.

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Ви можете отримати допомогу від сертифікованого та кваліфікованого медичного перекладача.

Nondiscrimination policy

IHN-CCO must follow state and federal civil rights laws. We cannot treat people (members or potential members) unfairly in any of our programs or activities because of a person's:

- Age.
- Disability.
- Gender identity.
- Marital status.
- National origin.
- Race.
- Religion.
- Color.
- Sex.
- Sexual orientation.
- Health status and need for services.

If you feel you were treated unfairly for any of the above reasons you can make a complaint or grievance.

Make (or file) a complaint with the IHN-CCO Grievance Coordinator in any of these ways:

- Phone: **541-768-1555**, toll free **800-832-4580** (TTY **800-735-2900**).
- Fax: 541-768-9765.
  Mail: IHN-CCO Appeals and grievances
  PO Box 1310
  Corvallis, OR 97339
- Email: **SHPOGrvcTeam@samhealth.org**
- Web: **IHNtogether.org/Your-Benefits/How-Do-I**

Need help filing a complaint? Call Customer Service at **541-768-4550** or **800-832-4580** (TTY **800-735-2900**). You also have a right to file complaint with any of these organizations:

Oregon Health Authority (OHA) Civil Rights

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

Bureau of Labor and Industries Civil Rights Division

- Phone: **971-673-0764**
- Web: **oregon.gov/boli/civil-rights/Pages/default.aspx**
- 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)

- Web: **ocrportal.hhs.gov/ocr/smartscreen/main.jsf**
- Phone: **800-368-1019**, (TDD **800-537-7697**)
- Email: **OCRComplaint@hhs.gov**
- Mail: Office for Civil Rights
  200 Independence Ave. SW, Rm 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 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. You can ask us for a list 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 Service and ask for our Notice of Privacy Practices. You can also see it at **samhealthplans.org/notice-of-privacy-practices**.

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?

- Ask to 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 IHN-CCO.

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

Welcome to InterCommunity Health Network Coordinated Care Organization

We are glad you are part of IHN-CCO. IHN-CCO 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 plan, how to get care and how to get the most from your benefits.

IHN-CCO is a managed care plan. We work with the Oregon Health Authority (OHA) to provide free health services to people enrolled in the Oregon Health Plan (OHP). IHN-CCO can manage the medical, dental and behavioral health care (mental health and substance use disorder treatment) for OHP members living in Benton, Lincoln and Linn counties. OHP will also help with prescriptions and rides to care. IHN-CCO offers the same benefits as the Oregon Health Plan.

We work with other organizations to help manage certain parts of your benefit, for example dental and transportation. For a full list of the organizations and descriptions of the services they offer see “Important Phone Numbers” on page 17.

For more details about how IHN-CCO is run and structured as a managed care plan, please call Customer Service at **541-768-4550** (TTY **800-735-2900**).

This member handbook is up to date. It was updated on Jan. 1, 2024. Read it and keep it as a guide for future use. The information in this handbook is updated at least once per year. If any changes are made to your benefits, we will tell you 30 days before the change takes place or as soon as possible. You can ask for a copy of this handbook. Call Customer Service and ask for a copy and we will mail you one within five business days. You can also ask for a copy by filling out the form online at **IHNtogether.org/ContactUs**.

Please see section “How OHP and IHN-CCO work together” to view a sample IHN-CCO member ID card. The ID card shows the IHN-CCO benefit packages. Review your IHN-CCO member ID card to see what benefit package you are enrolled in.

This IHN-CCO member handbook tells you about:

- What to do in an emergency.
- Your rights and responsibilities.
- Benefit information.
- How to file a grievance.
- How to appeal a decision you do not agree with.

You can find more details and member documents on our website at **IHNtogether.org**. The OHP handbook also gives you important details about your:

- OHP benefit packages.
- Covered and non-covered services.

You can ask for a copy by calling OHP Client Services at **800-273-0557** (TTY **711**). The Oregon Health Plan also has a website at **oregon.gov/oha/hsd/ohp/Pages/index.aspx**.

How OHP and IHN-CCO work together

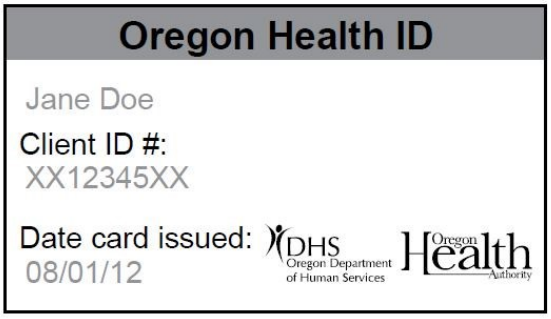
The Oregon Health Plan (OHP) is free health care coverage for Oregonians. OHP is Oregon's Medicaid program. It covers physical, dental and behavioral health care services (mental health and substance use disorder treatment). OHP will also help with prescriptions and rides to care.

OHP has local health plans that help you use your benefits. The plans are called coordinated care organizations or CCOs. IHN-CCO is a CCO. IHN-CCO serves Linn, Benton and Lincoln counties.

CCOs organize and pay for your health care. We pay doctors or providers in different ways to improve how you get care. This helps make sure providers focus on improving your overall health. You have a right to ask about how we pay providers. Provider payments or incentives will not change your care or how you get benefits. For more information, call Customer Service at **541-768-4550** (TTY **800-735-2900**).

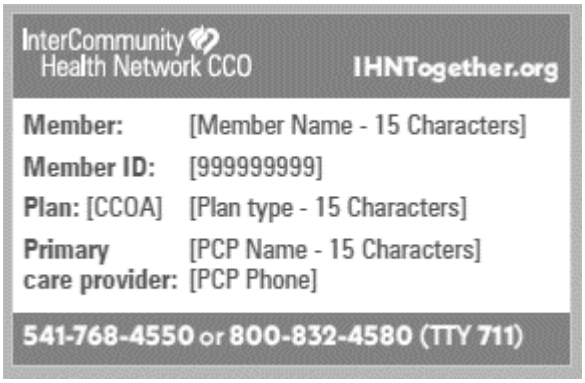
All CCOs offer the same OHP benefits. Some offer extra services like new baby items and gym memberships. Learn more about IHN-CCO benefits in the "Your benefits" section.
When you enroll in OHP, you will get an Oregon Health ID card. This is mailed to you with your coverage letter. Each OHP member in your household gets an ID card.

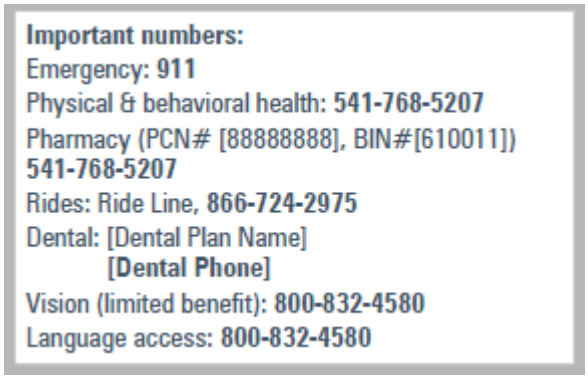
Your Oregon Health ID Card will look like this:



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) IHN-CCO member and lists other information like important phone numbers. Your primary care provider (PCP) will also be listed on your ID card.

Your IHN-CCO ID card will look like:





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

Your coverage letter and IHN-CCO 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 IHN-CCO office is open Monday through Friday, from 8 a.m. to 5 p.m.

We're closed on:

- New Year's day: Monday, Jan. 1
- Memorial day: Monday, May 27
- Independence day: Thursday, July 4
- Labor day: Monday, Sept. 2
- Thanksgiving day: Thursday, Nov. 28
- Christmas day: Wednesday, Dec. 25

Call us:

541-768-4550, toll free **800-832-4580** (TTY **800-735-2900**)
Oregon Relay **711**
Monday through Friday: 8 a.m. to 8 p.m.

Fax us:

Our fax number is 541-768-6701

Visit us:

2300 NW Walnut Blvd., Corvallis, OR 97330
Monday through Friday: 8 a.m. to 5 p.m.

Write us:

PO Box 1310, Corvallis, OR 97339

Email us:

IHNtogether.org/ContactUs

Important phone numbers

Free rides to physical care, dental care or behavioral health care available:
Cascade West Ride Line
Phone: **541-924-8738**, toll free **866-724-2975** (TTY **711**)
Monday through Friday, 8 a.m. to 5 p.m.

Medical benefits and care

Call Customer Service **541-768-4550** TTY users please call (TTY **800-735-2900**)
Hours: Monday through Friday, 8 a.m. to 8 p.m.
Learn more about medical benefits and care in section "Physical health benefits."

Pharmacy benefits

Call Customer Service **541-768-4550** TTY users please (TTY **800-735-2900**)
Hours: Monday through Friday, 8 a.m. to 8 p.m.
Learn more about pharmacy benefits in section "Prescription medications."

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

Behavioral health treatment agencies

Benton County

Benton County Behavioral Health
530 NW 27th St., Corvallis, OR 97330
Phone: **541-766-6835**
Fax: 541-766-6186
Monday through Friday: 8 a.m. to 5 p.m.

Samaritan Mental Health Family Center
3517 NW Samaritan Drive, Suite 101
Corvallis, OR 97330
Phone: **541-768-4620**
Fax: 541-768-4621
Monday through Friday: 8 a.m. to 5 p.m.
samhealth.org/FamilyCenter

Lincoln County

Lincoln County Behavioral Health — Child and Family
36 SW Nye St.
Newport, OR 97365
Phone: **541-265-4179**
Monday through Friday: 8 a.m. to 5 p.m. (closed from noon to 1 p.m.)
Some evenings are available by appointment only.
co.lincoln.or.us/hhs/page/lincoln-county-health-%20human-services

Lincoln County Behavioral Health — Adult Behavioral Health
51 SW Lee St.
Newport, OR 97365
Phone: **541-754-5960**
Monday through Friday: 8 a.m. to 5 p.m.
(closed from noon to 1 p.m.)
Some evenings are available by appointment only.

Lincoln County Behavioral Health — Lincoln City
4422 NE Devils Lake Blvd., Suite 2
Lincoln City, OR 97367
Phone: **541-265-4196**
Fax: 541-994-1882
Monday through Friday: 8 a.m. to 5 p.m. (closed from noon to 1 p.m.)
Some evenings are available by appointment only.

Linn County

Linn County Mental Health Services

Linncountyhealth.org/mental-health

Albany location:
445 3rd Ave. SW
Albany, OR 97321
Phone: **541-967-3866** or toll free **800-304-7468**. You can also call either of these numbers to reach the 24-hour crisis line any day of the week.
Monday, Wednesday, Thursday and Friday: 8:30 a.m. to 5 p.m.
Tuesday: 8:30 a.m. to 5 p.m.
Mail: PO Box 100
Albany, OR 97321

Lebanon location:
1600 S Main St.
Lebanon, OR 97355
Phone: **541-451-5932** or toll free **800-451-2631**. You can also call either of these numbers to reach the 24-hour crisis line any day of the week.
Monday through Friday: 8:30 a.m. to 5 p.m. (closed from noon to 1 p.m.)

Sweet Home location:
799 E Long St.
Sweet Home, OR 97386
Phone: **541-367-3888** or toll free **800-920-7571**. You can call either of these numbers to reach the 24-hour crisis line any day of the week.
Monday through Thursday: 8:30 a.m. to 5 p.m. (closed from noon to 1 p.m.)
Open some Fridays, call ahead to confirm

If you have a mental health emergency
Call a 24/7 crisis hotline:
Benton County: 888-232-7192
Lincoln County: 866-266-0288
Linn County: 866-266-0288
- or -
Call 911

988 Suicide and Crisis Lifeline

The **988 Suicide and Crisis Lifeline** is available 24 hours a day, seven days a week, every day of the year. It is for people having a behavioral health crisis. You can call, text or chat online at **988lifeline.org**. Calls may be answered in English or Spanish. Text and online chat are currently only available in English.

People can also dial **988** if they are worried about a loved one who may need crisis support. The 988 Suicide and Crisis Lifeline is easy to remember, like 911. It offers a direct link to trained crisis counselors who will offer care and support for anyone experiencing mental

health-related distress. This includes thoughts of suicide or self-harm, a substance use crisis or any other kind of behavioral health crisis. The counselor is part of a call center that is linked to a network of services, so the caller will be connected quickly with the right kind of help, from the right type of helper.

Dental benefits and care

Advantage Dental Services

442 SW Umatilla Ave., Redmond, OR 97756
Phone: **866-268-9631** (TTY **866-268-9617**)
Monday through Friday: 8 a.m. to 5 p.m.
advantagedental.com

Capitol Dental Care

3000 Market St. NE, Suite 228, Salem, OR 97301
Phone: **800-525-6800** (TTY **800-735-2900**)
Monday through Friday: 7 a.m. to 6 p.m.
capitoldentalcare.com

MODA/ODS

601 SW 2nd Ave., Portland, OR 97204
Phone: **800-342-0526** (TTY **800-342-0526**)
Monday through Friday: 7:30 a.m. to 5:30 p.m.
odscompanies.com/ohp

Willamette Dental Group

6950 NE Campus Way, Hillsboro, OR 97124

Phone: **855-433-6825** option 2, (TYY **800-735-1232**)

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

willamettedental.com

Contact the Oregon Health Plan

OHP Customer Service can help:

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

How to contact OHP Customer Service.

- Call toll free at **800-699-9075** (TTY **711**)
- Web: **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

As a member of IHN-CCO you have rights. There are also responsibilities or things you have to do when you get OHP. If you have any questions about the rights and responsibilities listed here, call Customer Service at **541-768-4550 (**TTY **800-735-2900**).

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 in section "You can make a complaint." You can also call an Oregon Health Authority Ombudsperson at **877-642-0450** (TTY **711**). You can send them a secure email at **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 **OHP.Oregon.gov**. Then 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

You have the right to be treated like this

• Be treated with dignity, respect and consideration for your privacy.
• Be treated by providers the same as other people seeking health care.
• Have a stable relationship with a care team that is responsible for managing your overall care.
• Not be held down or kept away from people because it would be easier to:
  o Care for you.
  o Punish you.
  o Get you to do something you don't want to do.

You have the right to get this information

• Materials explained in a way and in a language you can understand. (See section "Free help in other languages and formats").
• Materials that tell you about CCOs and how to use the health care system. Member Handbook is one good source for this.
• Written materials that tell you your rights, responsibilities, benefits, how to get services and what to do in an emergency. Member handbook is one good source for this.
• Information about your condition, treatments and alternatives, what is covered and what is not covered. This information will help you make good decisions about your care. Get this information in a language and a format that works for you.
• A health record that keeps track of your conditions, the services you get and referrals. (See section "Health records").
  o Have access to your health records.
  o Share your health records with a provider.
• Written notice mailed to you of a denial or change in a benefit before it happens. You might not get a notice if it isn't required by federal or state rules.
• Written notice mailed to you about providers who are no longer in-network. In-network means providers or specialists that work with IHN-CCO. (See section "Changes to IHN-CCO providers").
• Be told in a timely manner if an appointment is canceled.

You have the right to get this care

- Care and services that put you at the center. Get care that gives you choice, independence and dignity. This care will be based on your health needs and meet standards of practice.
- Services that consider your cultural and language needs and are close to where you live. If available, you can get services in non-traditional settings such as online. (See section "Getting care by video or phone").
- Care coordination, community-based care and help with care transitions in a way that works with your culture and language. This will help keep you out of a hospital or facility.
- Services that are needed to know what health condition you have.
- Help to use the health care system. Get the cultural and language support you need. (See section "Traditional health worker"). This could be:
    - Certified or qualified health care interpreters.
    - Certified traditional health workers.
    - Community health workers.
    - Peer wellness specialists.
    - Peer support specialists.
    - Doulas.
    - Personal health navigators.
- Help from CCO staff who are fully trained on CCO policies and procedures.
- Covered preventive services. (See section "Physical health benefits").
- Urgent and emergency services 24 hours a day, seven days a week without approval or permission. (See sections "Urgent care" and "Emergency care").
- Referrals to specialty providers for covered coordinated services that are needed based on your health. (See section "Provider referrals and self-referrals").
- Extra support from an OHP Ombudsperson (see section "Your rights and responsibilities" above this chart).

You have the right to do these things

- Choose your providers and to change those choices. (See section "Primary care providers (PCPs)").
- Get a second opinion. (See section "Second opinions").
- Have a friend, family member or helper come to your appointments.
- Be actively involved in making your treatment plan.
- Agree to or refuse services. Know what might happen based on your decision. A court-ordered service cannot be refused.
- Refer yourself to behavioral health or family planning services without permission from a provider.
- Make a statement of wishes for treatment. This means your wishes to accept or refuse medical, surgical, or behavioral health treatment. It also means the right to make directives and give powers of attorney for health care, listed in ORS 127. (See section "End of life decisions").

- Make a complaint or ask for an appeal. Get a response from IHN-CCO when you do this. (See section “Complaints, Grievances, Appeals and Fair Hearings”).
    - Ask the state to review if you don’t agree with IHN-CCO’s decision. This is called a hearing.
- Get free certified or qualified health care interpreters for all non-English languages and sign language. (See section “Free help in other languages and formats”).

Your responsibilities as an OHP member

You must treat others this way
• Treat IHN-CCO staff, providers and others with respect. • Be honest with your providers so they can give you the best care.
You must tell OHP this information
Call OHP/ONE Customer Service line at **800-699-9075** (TTY **711**) when you: o Move or change your mailing address. o If any family moves in or out of your home. o Change your phone number. o Become pregnant and when you give birth. o Have other insurance.
You must help with your care in these ways
• Choose or help choose your primary care provider or clinic. • Get yearly checkups, wellness visits, and preventive care to keep you healthy. • Be on time for appointments. If you will be late, call ahead or cancel your appointment if you can’t make it. • Bring your medical ID cards to appointments. Tell the office that you have OHP and any other health insurance. Let them know if you were hurt in an accident. • Help your provider make your treatment plan. Follow the treatment plan and actively take part in your care. • Follow directions from your providers’ or ask for another option. • If you don’t understand, ask questions about conditions, treatments and other issues related to care. • Use information you get from providers and care teams to help you make informed decisions about your treatment. • Use your primary care provider for test and other care needs, unless it’s an emergency. • Use in-network specialists or work with your provider for approval if you want or need to see someone who doesn’t work with IHN-CCO. • Use urgent or emergent services appropriately. Tell your primary care provider within 72 hours if you do use these services. • Help providers get your health record. You may have to sign a form for this. • Tell IHN-CCO if you have any issues, complaints or need help. • Pay for services that are not covered by OHP. • If you get money because of an injury, help IHN-CCO get paid for services we gave you because of that injury.

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 clinics. Find a clinic at **Ihs.gov/findhealthcare**.
- Native American Rehabilitation Association of the Northwest. Learn more or find a clinic at **naranorthwest.org**.

You can use other clinics that are not in our network. Learn more about referrals and preapprovals in section “Your benefits”.

American Indian and Alaska Natives don’t need a referral or permission to get care from these providers. These providers must bill IHN-CCO. 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 IHN-CCO any time and have OHP Fee-For-Service (FFS) pay for their care. Learn more about leaving or changing your CCO in section “Changing CCOs and moving care”.

New members who need services right away

Members who are new to OHP or IHN-CCO may need prescriptions, supplies, or 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 IHN-CCO:

- Call Customer Service at **541-768-4550** (TTY **800-735-2900**) and ask for Care Coordination. They can help you get the care you need. Care coordination can help OHP members with Medicare, too. (See section “Get help organizing your care with care management” for Care Coordination).
- Make an appointment with your PCP as soon as you can. You can find their name and number on your IHN-CCO ID card.
- Call Customer Service at **541-768-4550** (TTY **800-735-2900**) if you have questions and want to learn about your benefits. They can help you with what you need.

Primary care providers

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

You can change your PCP at any time by calling Customer Service at **541-768-4550** (TTY **800-735-2900**). We work with some providers, but not all of them. A current list of in-network PCPs can be found on our website at **IHNtogether.org/FindCare** or you can call our Customer Service.

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 IHN-CCO about a dentist, mental health provider and pharmacy.

It is important that you get regular dental exams and cleanings for preventive care. You need to choose a clinic or dental office as your primary care dentist (PCD). Your PCD will arrange all your dental care. Your PCD will also send you to a specialist if you need to go. Please call your dental plan's customer service for your PCD's name, phone number, address and office hours. It is important to choose a provider office near your home. If you do not know which dental plan you are assigned to, call Customer Service for help. See "Handbook updates" on page 2. If you wish to change your PCD, contact your dental plan. You can access provider directories for your dental plan by going to **IHNtogether.org/Dental**.

Please call Customer Service at **541-768-4550** (TTY **800-735-2900**), Monday through Friday, 8 a.m. to 8 p.m. if you would like to change your PCP, PCD or other providers. You can start seeing your new PCP, PCD or other providers on the day this change is made.

In-network providers

IHN-CCO 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 section "Changing CCOs and moving care").
- You are American Indian or Alaskan Native (see section "American Indian and Alaskan Native members").

Provider directory

You can choose your PCP, PCD or other providers from the provider directory at: **IHNtogether.org/FindCare**. You can also call Customer Service for help.

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. You can get it in another format (such as other languages, large print or Braille) for free. Call Customer Service at **541-768-4550** (TTY **800-735-2900**).

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 checkup. 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 an IHN-CCO member.
- Your name and IHN-CCO 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 in section “Free rides to care”.

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 by calling Customer Service. We work with some providers, but not all of them. A current list of in-network PCPs can be found on our website at **IHNtogether.org/FindCare** or you can call our Customer Service at **541-768-4550** (TTY **800-735-2900**).

Changes to IHN-CCO providers

We will tell you when one of your regular providers stops working with IHN-CCO. 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 IHN-CCO Customer Service and tell us you want to see another provider.

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 IHN-CCO customer service for help. We will arrange the second opinion for free.

Survey about your health

Shortly after you enroll, IHN-CCO will call you with a survey about your health. This survey is called a "Survey About Your Health".

Complete and return your survey in any of these ways:

- Phone: **541-768-4550**, toll free **800-832-4580** (TTY **800-735-2900**)
- Fax: 541-768-6701
- Mail: IHN-CCO
  PO Box 1310
  Corvallis, OR 97339
- Email: **IHNtogether.org/ContactUs**

The "Survey About Your Health" is a survey with questions about your general health with the goal of helping reduce health risks, maintain health and prevent disease.

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 Management 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 section "Get help organizing your care with Care Management" for Care Coordination.

You may self-refer and no prior approval is needed to take the Survey About Your Health. Answers from your Survey About Your Health may be shared among your health care teams to provide you with the best care.

A Care Management 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, we will reach out to help make sure it is completed within 90 days of enrollment. If you want us to send you a survey you can call IHN-CCO Customer Service at **541-768-4550** (TTY **800-735-2900**) and we will send you one.

Your survey may be shared with your doctor or other providers. IHN-CCO will ask for your permission before sharing your survey with providers.

Members who are pregnant

If you are pregnant, OHP provides extra services to help keep you and your baby healthy. When you are pregnant, IHN-CCO can help you get the care you need. It can also cover your delivery and 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.** Child-birthing and Lamaze classes are covered if done at a hospital in IHN-CCO's service area. For more details, call IHN-CCO Customer Service at **541-768-4550** (TTY **800-735-2900**).

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 IHN-CCO.
- **Get a free nurse home visit with Family Connects Oregon. It is nurse home visiting program that is free for** all families with newborns. A nurse will come to you for a checkup, newborn tips and resources. For more details on Family Connects in your area visit **familyconnectsoregon.org/linn-lincoln-and-benton**.

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 heathier.

If you have any questions, please call us at **541-768-4550** (TTY **800-735-2900**).

Get help organizing your care with Care Management

You get Care Management from your patient-centered primary care home (PCPCH), primary care provider, IHN-CCO or other primary care teams. You can visit **IHNtogether.org/Care-Coordination** for more information about Care Coordination.

IHN-CCO have staff that are part of your Care Management team. IHN-CCO 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.

Working together for your care

Your Care Management team will:

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

Your Care Management 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.

The purpose of Care Management is to make your overall health better. We will work together to help find out your health care needs and help you take charge of your health and wellness.

Your Care Management team will work closely with you. They will connect you with community and social support resources that may help you. This team will include different people who will work together to meet your needs, such as providers, specialists and community programs you work with. Your care team's job is to make sure the right people are part of your care to help you reach your goals. We will all work together to support you.

You and your assigned care team will make a plan called a care plan. This plan will help meet your needs. Your 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.

If your Care Management Coordinator changes, a warm handoff to a new coordinator will be completed if possible. Otherwise you will be informed of the change during your next outreach or we will send you a letter.

Care Management availability

Care Management services are available Monday through Friday, 8 a.m. to 5 p.m. Exceptions can be made for members who notify us that they cannot receive calls during regular business hours.

Call IHN-CCO at **541-768-4877** for more information about Care Management. If you have complex medical or behavioral health needs, please ask about our Care Management services.

All IHN-CCO members may access Care Management services with one of the team of Community Health Workers by calling **541-768- 4877** or emailing **CareCoordinationTeam@samhealth.com**. Members who would like Care Management will get a welcome letter with the name of their assigned Care manager and how to contact them.

Maternity Care Management is an option for people with high-risk pregnancy. We can help you find care and resources. We provide education:

- To help reduce the risk of low-birth-weight babies.
- For prematurity.
- Other complications of pregnancy.

Members with Medicare

You can also get help with your OHP and Medicare benefits. A staff from IHN-CCO Care Management 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.

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 age 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 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 section "Comprehensive and preventive benefits for members under age 21" for more information on coverage for members under 21.

Learn more about the Prioritized List at **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. See the charts below for services that are direct access and do not need a referral or preapproval.

No referral or preapproval needed

You do not need a referral or preapproval for some services. This is called direct access.

These services do not need a referral or preapproval:

- **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.
- **Sexual abuse exams**.
- **Behavioral Health Assessment and Evaluation services**.
- **Outpatient and Peer-Delivered Behavioral Health services** from an in-network provider.
- **Care Management services** available for all members.

Getting preapproval

Some services, like surgery or inpatient services, need approval before you get them. This is to make sure that the care is medically needed and right for you. Your provider will take care of this. 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, IHN-CCO may still need to review your case to make sure that you should receive the service.

You should know that these decisions are based only on whether the care or service is right for you and if you are covered by IHN-CCO. IHN-CCO does not reward providers or any other persons for issuing denials of coverage or care. Extra money is never given to anyone who makes a decision to say no to a request for care. Contact IHN-CCO Customer Service at **541-768-4550** (TTY **800-735-2900**) 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 section "You can make a complaint" for how to file a complaint.

If you need a preapproval for a prescription, we will make a decision within 24 hours. If we need more information to make a decision, it can take 72 hours.

See section "Prescription medications" to learn about prescriptions.

You do not need approval for emergency or urgent services or for emergency aftercare services. See section "Emergency care" to learn about emergency services.

Services that need prior approval

- **Inpatient Hospital services.**
- **Inpatient Substance Use Disorder Residential and Detox services.**
- **Elective/planned surgeries performed in an operating room, surgical suite, hospital or ambulatory surgery center.**
- **Root canal therapy on molars.**

This is not a complete list of services that require prior approval. For a full list go to **IHNtogether.org/PriorApproval** or call IHN-CCO Customer Service at **541-768-4550** (TTY **800-735-2900**).

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.

For example: 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 IHN-CCO for approval.

If there is not a specialist close to where you live or a specialist who works with IHN-CCO (also called in-network), they may have to work with the Care Management 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. You do not need a referral if you are having an emergency.

Services that need a referral

- **Medication Assisted Treatment for Substance Use Disorder.**

- **Specialist services.**
  If you have special health care needs, your health care team can work together to get you access to specialists without a referral.

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.**

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 in section "Provider directory".

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 services.
- Routine vision providers in the network.
- Dental providers in the network.
- Family planning services in or out of network.
- Mental health services for problems with alcohol or other drugs.
- Assertive Community Treatment.

Prior approval may still be needed for a service when you use self-referral. Talk with your PCP or contact Customer Service if you have questions about if you need a prior approval to get a service.

Benefits charts icon key

Services that need prior approval

Some services need approval before you get the service. Your provider must ask the CCO for approval. This is known as a prior approval.

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 prior approval needed

You do not need a referral or prior approval 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 "How to access" column to see if you need to get a referral or preapproval for the service. IHN-CCO 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. See section "Comprehensive and preventative benefits for members under age 21" for more details.

Service	How to access	Who can get it
Care Coordination services You have access to care coordinators, social workers and community health workers that can help find ways to meet your health care needs. See section "Get help organizing your care with Care Coordination" for more details.	 No referral or prior approval	All members
Comfort care and hospice services Care to comfort a person who is dying and their family. Hospice can include pain treatment, counseling and respite care.	 No referral or prior approval	All members
Diagnostic services Services to diagnose or manage your condition even if the condition would not be covered by OHP. Examples may include: • Labs. • Tests. • Bloodwork.	 No referral or prior approval	All members
Durable Medical Equipment A kind of equipment that lasts a long time. Devices that are prescribed by your doctor for use at home. Some examples are: • Medical supplies (including diabetic supplies). • Medical appliances (including hospital beds, walkers, wheelchairs). • Prosthetics and orthotics. • Breast pumps.	 Prior approval needed for billed amounts over $500 or rental length greater than 3 months	All members

Well-Child Care, Early & Periodic Screening, Diagnosis and Treatment (EPSDT) services **These services cover the care children and youth up to age 21 need for their health development.** **Some EPSDT services might be:** • Screenings. • Checkups. • Tests. • Follow-up care. Well-child visit limits based on guidelines from Bright Futures and the American Academy of Pediatrics. See section "Comprehensive and preventive benefits for members under age 21" for more details.	 No referral or prior approval	Members ages 0-20 years old
Elective surgeries/procedures **A surgery that is planned in advance and can be postponed if needed.** Prior approval is required except for GI, ear, nose and throat endoscopies, and colonoscopies. Some in office-procedures may require approval. May be limits depending on the service.	 Prior approval needed	All members
Emergency medical transportation A ride to the hospital in an ambulance is covered without prior approval if it is an emergency.	 No referral or prior approval	All members
Emergency services Care that improves or stabilizes sudden serious medical or mental health conditions. Some emergencies might be: • Bleeding that will not stop. • Broken bones. • Chest pain. • Mental health emergency. • Trouble breathing.	 No referral or prior approval	All members

Family planning services These services are used to prevent or delay pregnancy. Services include: • Annual exams. • Birth control and education. • Lab tests. • Screenings. • Radiological services and medical procedures. You can go to an out-of-network provider for family planning services and supplies. Sterilization requires consent form be fully completed by a provider and member within the required timeframe before procedure. Call Customer Service at for **541-768-4550** (TTY **800-735-2900**) for details.	 No referral or prior approval	All members
Gender affirming care **This care includes services to help people align various aspects of their lives – emotional, interpersonal, and biological with their gender identity.** Gender affirming care is sensitive and responsive to an individual's gender identities and expressions. Gender affirming care complies with non-discrimination laws.	 No referral or prior approval	All members when medically necessary
Hearing services **Services to help maximize a person's hearing and communication abilities.** Hearing exams and screenings do not need prior approval and have no limits. Hearing services may include: • Exams. • Screenings. • Hearing aides. Prior approval is required for hearing aids if billed amount is over $500. • 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.*	 Prior approval needed for billed amounts over $500	All members
Home health services Services you get at home to help you live better after surgery, an illness or injury. Help with wound care, drugs, meals and bathing are some of these services. Non-medical assistance is not included and is not covered.	 No referral or prior approval	All members

Immunizations and travel vaccines Immunizations (vaccines) are a simple, safe, and effective way of protecting people against harmful diseases, before they come into contact with them. Examples may include: • Hepatitis. • Tdap. • Prevnar 13. Travel vaccines are to protect travelers from serious diseases. Examples may include: • COVID-19. • MMR (mumps, measles, rubella). Preventive vaccines: • Age 17 and younger: Vaccines must be given at a providers office. • Age 18 and older: Covered vaccines may be given at a providers office, in-network pharmacy or health department. Immunizations for work, education or foreign travel are covered.	 No referral or prior approval	All members
Inpatient hospital services Inpatient hospital services are when you are admitted to the hospital and stay at least 3 nights. Examples may include: • Childbirth. • Serious illness. Prior approval is <u>not</u> required for emergency services.	 Prior approval needed	All members
Interpreter services You can get a free certified/qualified health care interpreter for all non-English languages and sign language for your covered visits. You can get a free phone interpreter for telehealth services.	 No referral or prior approval	All members
Laboratory services, X-rays and other procedures Some examples are: • Blood draws. • CT scans. • MRIs. • X-rays.	 Prior approval needed for some MRIs	All members

Maternity services Prenatal visits with your provider, postpartum care (care you get after your baby is born), child-birth classes. For more details, see “Members who are pregnant” section.	 No referral or prior approval	Pregnant members
Rides to care. Also called Non-Emergent Medical Transportation (NEMT) services Rides to covered services are available at no cost to you. You can get a ride 24 hours a day, every day of the year. We can also help you get a ride to a service that is non-covered if you have care coordination with us. See section “Free rides to care” for more details.	 Prior approval from Ride Line is required for reimbursement of mileage, meals and lodging to covered health services	All members
Outpatient hospital services Outpatient hospital services are when surgery or treatment is performed in a hospital and you leave right after. Examples may include: • Chemo. • Radiation. Some services may require prior approval.	 Prior approval needed	All members
Pharmaceutical services (prescription medication) Contraceptives: Up to a 90-days (three month supply) with a prescription. Other medications: Up to a 34-day (one month) supply with a prescription. Some prescribed drugs require prior approval. Mental health drugs are covered by OHP (not covered by IHN-CCO.	Prescription needed	All members

Physical therapy, occupational therapy, speech therapy Physical therapy is used to restore body function, such as standing, walking and moving different body parts. Examples may include: • Stretching. • Electrical stimulation. Occupational therapy focuses on improving your ability to perform activities of daily living. Examples may include: • Helping you complete essential tasks like getting dressed or brushing your teeth. Speech therapy is training to help people with speech and language problems to speak more clearly. Examples may include: • Improving pronunciation. • Strengthening the muscles used in speech. • Learning to speak correctly. Prior approval needed if more than 30 visits per calendar year, per service. No limit on visits for the first year following a serious injury to the spinal cord, traumatic brain injury or a cerebral vascular injury.	 Prior approval needed	All members
Preventive services Preventative services is health care that keeps you well. Some examples are: • Well-baby care. • Immunizations. • Women's health (mammogram, gynecological exam, etc.). • Screenings (cancer, sexually transmitted diseases). • Diabetes prevention. • Nutritional counseling. • Tobacco cessation services Routine physicals limited to once per year.	 No referral or prior approval	All members
Primary care provider visits A visit with the provider 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. PCPs help manage your regular medical care and treatment, such as routine and preventive services. They will make sure you can see specialists when needed. See section "Primary care providers" for more details.	 No referral or prior approval	All members

Sexual abuse exams Medical exam of a victim of sexual assault given within the standard of care by a medical doctor. Examples may include: • Physical exam. • Collection of samples.	 No referral or prior approval	All members
Specialist services Visits with a provider who has training to care for a certain part of the body or type of illness. Abortion (covered by OHP, not covered by IHN-CCO) Examples are: Chiropractic (approval and limits based on OHP guidelines), cardiology, audiology, behavioral health. A referral from your PCP to a specialist may be needed.	 No prior approval  Some services may require referral from your PCP	All members. For those with special health care needs or LTSS, no referral is required.
Surgical procedures Medical procedures involving incision (cut) to repair damage. Elective/planned surgeries performed in an operating room, surgical suite, hospital or ambulatory surgery center (ASC) require prior approval. Prior approval is not required for: • Colonoscopies. • gastrointestinal (GI) endoscopies (with and without biopsies). • Ear, nose and throat (ENT) endoscopies (with or without biopsies). • Coronary angioplasty.	 Prior approval needed	All members
Telehealth services Telehealth/telemedicine is a way for you to get care through phone or video without going into a clinic. Ask your provider about telehealth when you call to make your appointment. Some examples are: • Telemedical. • Teledentistry services. • Virtual visits and email visits. See section “Getting care by video or phone” for more details.	 No referral or prior approval	All members

Traditional Health Worker (THW) services A public health worker who works with health care providers to serve a community or clinic. A THW makes sure members are treated fairly. Some examples of THWs are: • Birth doulas. • Community health workers. • Personal health navigators. • Peer support specialists. • Peer wellness specialists. • Tribal traditional health workers. See section “Traditional Health Workers” for more details.	 No referral or prior approval	All members
Urgent care services Health services that require immediate attention to prevent further harm. Some examples are: • Cuts that don’t involve much blood but might need stitches. • Minor broken bones and fractures in fingers and toes. • Sprains and strains. Urgent care services are covered anywhere in the U.S. without prior approval. See section “Urgent care” for more details.	 No referral or prior approval	All members
Women’s Health Services (in addition to PCP) for routine and preventive care These services are unique to women’s needs, such as • Screening for osteoporosis. • Screening for breast and cervical cancer. • Treatment for menstrual bleeding disorders.	 No referral or prior approval	All members

Vision services **Non-pregnant adults (21+) are covered for:** • Routine eye exams at least every 24 months • Medical eye exams when needed. o Corrective lenses/accessories only for certain medical eye conditions. **Members under 21*, pregnant adults, adults up to 12 months post-partum are covered for:** • Routine eye exams at least 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.	 Prior approval required for contact lenses	All Members

The table above is not a full list of services that need prior approval or referral. If you have questions, please call IHN-CCO Customer Service at **541-768-4550** (TTY **800-735-2900**).

Behavioral health care benefits

See below for a list of behavioral health benefits that are available to you at no cost. 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. Look At the "How to access" column to see if you need to get a referral or preapproval for the service. IHN-CCO 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. See section "Comprehensive and preventative benefits for members under age 21" for more details.

Service	How to access	Who can get it
Care Coordination services You have access to care coordinators, social workers and community health workers that can help find ways to meet your health care needs. See section "Get help organizing your care with Care Coordination" for more details.	 No referral or prior approval	All members
Assertive Community Treatment (ACT) Mental health services provided in a community setting to people experiencing serious mental illness. No limits.	 No referral or prior approval	All members

Wraparound services Youth and families will work with a team of individuals trained to support youth and their families. Together they will create a plan of care. This is a crisis and safety plan that helps youth and family members move toward their goals and vision for the future.	 No referral or prior approval	Children and youth that meet medical criteria
Behavioral Health Assessment and Evaluation Services A series of questions to provide a doctor with a more complete picture of the way a patient thinks, feels, reasons and remembers. No limits.	 No referral or prior approval	All members
Inpatient substance use disorder residential and detox services Inpatient treatment, sometimes called residential treatment, is the highest level of rehab care for people who are diagnosed with alcohol addiction or other drug addiction (known medically as substance use disorder). Examples may include: • Rehabilitation. • Detox. • Mental health services.	 Prior approval required	All members
Medication Assisted Treatment (MAT) for Substance Use Disorder (SUD) The use of medications along with counseling and behavioral therapies for the treatment of SUD.	 No referral or prior approval	All members
Outpatient and peer delivered behavioral health services from an in-network provider. You have a right to treatment in your own language and to feel safe with your provider. Peer delivered services are a way for you to connect with someone who has lived experience of recovery and special training, so they understand what you are going through. Peers can help you: • Set goals. • Manage your appointments. • Assist you in finding services you need. • Provide additional support to clinical services. Peers can work in a treatment center or in a community organization. They are there to help you and your family.	 No referral or prior approval	All members

Behavioral Health Specialist Services **These are services that help with:** • Mental health. • Mental illness. • Addiction. • Substance use disorders. A referral from your PCP to a specialist may be needed.	 No prior approval	All members
Substance Use Disorder (SUD) services You can talk to your doctor or call a drug and alcohol provider yourself. These programs have trained staff and services to help people quit and develop skills to maintain long-term recovery. Some of these services include: • Residential. • Detoxification services. • Outpatient services. • Peer delivered services. You can also get additional help if you have other things like depression or disabilities which add to your use of drugs or alcohol.	 Prior approval required for hospitalization, residential and detoxification services	All members

The table above is not a full list of services that need preapproval or referral. If you have questions, please call IHN-CCO Customer Service at **541-768-4550** (TTY **800-735-2900**).

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:

- Can help prevent pain.
- Healthy teeth 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.
- Fixing dental problems can help you control your blood sugar.
- Children should have their first dental checkup 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).
- Pediodontist (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).

Please see the table below for 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 “How to access” column to see if you need to get a referral or preapproval for the service.

Sometimes you may need to see a specialist. Common dental services that may need to be referred to a specialist are:

- Oral surgery.
- Hospital or surgery center.
- Root canals.
- Gum issues.
- In-office sedation.

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. See section “Comprehensive and preventative benefits for members under age 21” for more details.

Service	How to access	Who can get it
Care Coordination services You have access to care coordinators, social workers and community health workers that can help find ways to meet your health care needs. See section “Get help organizing your care with Care Coordination” for more details.	 No referral or prior approval	All members
Emergency and urgent dental care **Dental services that require immediate attention to prevent further harm.** Examples may include: • A tooth that has been knocked out. • Serious abscess. • Severe swelling or infection of the gums around a tooth. • Severe tooth pain. No limits.	 No referral or prior approval	All members
Oral exams Your dentist will look inside your mouth and face to determine oral diseases. Those under 21 years old: Twice a year.* All other members: Once a year.	 Referral needed if not seeing your PCD	All members
Oral cleanings Your dentist will use special tools to clean your teeth and gums. Members under 19: Twice a year * or based on medical necessity and dental appropriateness. Members 19 years of age and older: Once a year*	 No referral or prior approval	All members

Fluoride varnish **A liquid applied to teeth to help prevent tooth decay.** Members through age 18: Twice a year *Members up to age 19: Twice a year.* Members up to 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 prior approval	All members
Oral X-rays Your dentist will take pictures of your teeth to help detect oral diseases. Limited to once a year.	 No referral or prior approval	All members
Sealants This treatment seals out decay in hard to brush areas of your teeth. Under Age 16. On adult back teeth once every five years or based on medical necessity and dental appropriateness.*	 No referral or prior approval	Members under age 16
Fillings Repair damage caused by tooth decay. Maybe be silver or tooth colored. There are no limits.	 No referral or prior approval	All members
Partial or complete dentures A removable plate or frame holding fake teeth. Partial: Once every five years. Complete: Once every 10 years. Members age 16 years and older* For members 21 years of age and older, adjustments and repairs of dentures are covered up to four times per year, depending on the repair needed. Denture reline is covered every three years for members under 20 years old and once every five years for members 21 years and older.	 Prior approval needed for partial and complete dentures	All members
Crowns Tooth shaped cap used to restore weak, broken or decayed teeth that fits over your entire tooth. Benefits vary by type of crown, specific teeth requiring care, age, and pregnancy status. Contact your dental health plan.		Pregnant members or members under age 21*

Some upper and lower front teeth. Four crowns every seven years. *	Referral needed if not seeing your PCD	
Extractions **A dental procedure that completely removes teeth.** Wisdom teeth are a limited benefit. No limit for other services	 Referral needed if not seeing your PCD	All members
Root canal therapy **Removal of pulp/blood supply of a decaying or infected tooth.** Under 12: Not covered on third molars (wisdom teeth). Pregnant members: Covered on first molars. All other members: * Only on front teeth and pre-molars.	 Referral needed if not seeing your PCD	All members
Orthodontics **The process of straightening teeth, often using braces.** Only covered in cases such as cleft lip and palate, or when speech, chewing and other functions are affected.*	 Prior approval needed	Members under 21

The table above is not a full list of services that need preapproval or referral. If you have questions, please call Customer Service at **541-768-7450** (TTY **800-735-2900**).

If you have a dental emergency, call your dentist or dental plan first.

Advantage Dental Services: 866-268-9631 (TTY **866-268-9617**)

Capitol Dental Care: 800-525-6800 (TTY **800-735-2900**)

MODA/ODS: 800-342-0526 (TTY **800-342-0526** or **711**)

Willamette Dental Group: 855-433-6825 option 1 (TTY **800-735-1232**)

Your dental provider will manage your dental care and treatment.

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

If you are a member of the Veteran Dental Program or 5OFA Dental Program ("OHP Dental"), IHN-CCO **only** provides dental benefits and free rides to dental appointments.

OHP and IHN-CCO do not provide access to physical health or behavioral health services or free rides for these services.

If you have questions regarding coverage and what benefits are available, contact Customer Service at **541-768-4550** (TTY **800-735-2900**).

Services that OHP pays for

IHN-CCO 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 Management from IHN-CCO.
2. Services where you get Care Management from OHP.

Services with IHN-CCO care coordination

This means that we will provide care management and transportation, even when you get the following services that we do not cover. Some, but not all, of these services include:

- Out of hospital births (OOHB), also called planned community birth. This includes prenatal and postpartum care for people having a low-risk pregnancy. Low-risk pregnancy is defined by OHA. The Oregon Health Authority will pay for OOHB services, including at a minimum:
    - Newborn initial assessment.
    - Newborn bloodspot screening test, including the screening kit, labor and deliver care, prenatal visits and care after birth.
- Some long-term services and supports.
- Family Connects Oregon, which provides support to families and newborns. Find more information about Family Connects Oregon at **familyconnectsoregon.org**.
- Helping you get access to some behavioral health services. Some of these are:
    - Certain drugs for some behavioral health issues.
    - Therapeutic group home reimbursement for members under 21 years of age.
    - Long term psychiatric care for members 18 and older.
    - Personal care in adult foster homes for members 18 and older.

For more information or for a complete list about these services, call Care Management at **541-768- 4877** or Customer Service at **541-768-4550** (TTY **800-735-2900**).

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 Care Management team at **800-562-4620** for more information and help with these services.

You can still get a free ride from Ride Line for any of these services. See section "Free rides to care" for more details. Call Ride Line at **541-924-8738** or toll free **866-724-2975** to schedule a ride or ask questions.

Moral or religious objections

IHN-CCO 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 IHN-CCO does not work with a provider who meets your access needs, you can get these services out-of-network. IHN-CCO 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.

IHN-CCO 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.

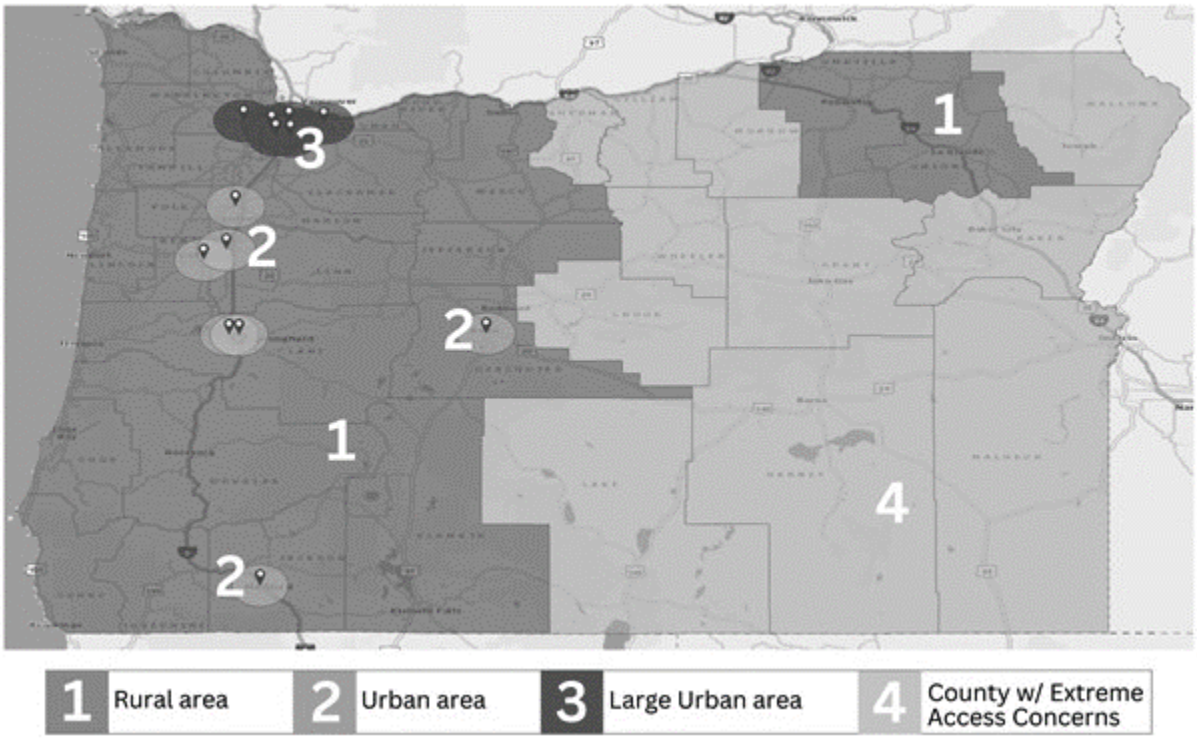
	Large urban	Urban	Rural	County with extreme access considerations
Tier 1	10 mins or 5 miles	25 mins or 15 miles	30 mins or 20 miles	40 mins or 30 miles
Tier 2	20 mins or 10 miles	30 mins or 20 miles	75 mins or 60 miles	95 mins or 85 miles
Tier 3	30 mins or 15 miles	45 mins or 30 miles	110 mins or 90 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 **oregon.gov/oha/HSD/OHP/Pages/network.aspx**.

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.



Our providers will also make sure you will have physical access, reasonable accommodations and accessible equipment if you have physical and/or mental disabilities. Contact IHN-CCO at **541-768-4550** (TTY **800-735-2900**) to request accommodations. 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 below:

Care type	Timeframe
Physical health	
Regular appointments	Within four 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 eight weeks unless there is a clinical reason to wait longer.
Urgent oral care	Within two weeks.
Dental emergency services	Seen or treated within 24 hours
Oral and dental care for pregnant people	
Routine oral care	Within four weeks unless there is a clinical reason to wait longer.
Urgent dental care	Within one week
Dental emergency services	Seen or treated within 24 hours
Behavioral health	

Care type	Timeframe
Routine behavioral health care for non-priority populations	Assessment within seven days of the request, with a second appointment scheduled as clinically appropriate.
Urgent behavioral health care for all populations	Within 24 hours
Specialty behavioral health care for priority populations*	
Pregnant people, veterans and their families, people with children, unpaid caregivers, families and children ages zero to five years, members with HIV/AIDS or tuberculosis, members at the risk of first episode psychosis and the I/DD population	Immediate assessment and entry. If interim services are required because there are no providers with visits, treatment at proper level of care must take place within 120 days from when patient is put on a waitlist.
IV drug users including heroin	Immediate assessment and entry. Admission for services in a residential level of care is required within 14 days of request or placed within 120 days when put on a waitlist because there are no providers available.
Opioid use disorder	Assessment and entry within 72 hours
Medication assisted treatment	As soon as possible, but no more than 72 hours for assessment and entry.

* For specialty behavioral health care 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 Service at **541-768-4550** (TTY **800-735-2900**).

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 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; if you are under age 21 and enrolled in OHP you will receive these benefits.

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 under age 21.
- Referrals, treatment, therapy and other measures to help with any conditions discovered.

For members under age 21, IHN-CCO has to give:

- Regularly scheduled examinations and evaluations of physical, mental health, developmental, oral/dental health, growth, and nutritional status.
    - If your IHN-CCO doesn't cover oral/dental health, you can still get these services through OHP by calling **800-273-0557**.
- Starting Jan. 1, 2024, all medically necessary and medically appropriate services must be covered for members under 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 section "How Oregon decides what OHP will cover".

Under EPSDT, IHN-CCO 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, effective, and helps you participate in care and activities. IHN-CCO 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 section "You can ask us to change a decision we made. This is called an appeal."

This includes **all** services:

- Physical health.
- Behavioral health.
- Dental health.
- Social health care needs.

If you or your family member needs EPSDT services, work with your primary care provider or talk to a care coordinator by calling **541-768-4550** (TTY **800-735-2900**). 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 Service at **541-768-4550** (TTY **800-735-2900**).
- Call your dental plan to set up dental services or for more information.
- You can free get rides to and from covered EPSDT provider visits. Call **541-924-8738**, toll free **866-724-2975**, (TTY **711**) Monday through Friday, 8 a.m. to 5 p.m.to set up a ride or for more information.
- You can also ask your PCP or visit our website at **IHNogether.org/For-Children**. 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). IHN-CCO 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:

- Developmental screening.
- 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):
    - **https://www.cdc.gov/vaccines/schedules/hcp/imz/child-indications.html#addendum-child**
    - Adult immunization schedule (19+): **cdc.gov/vaccines/schedules/hcp/imz/adult.html#addendum-adult**
- 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 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.

IHN-CCO 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 under 21 years old who need them. Treatments that are “below the line” on the Prioritized List of Health Services are covered for members under 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 section “Learn more about the steps to ask for an appeal or hearing”.

IHN-CCO 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 **Oregon.gov/EPSDT** and view a member fact sheet.

Traditional Health Workers

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. There is no referral required for the use of services from a Traditional Health Worker.

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.

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.

Call our THW liaison to find out more about THWs and how to use their services.

THW liaison contact information:

Alicia Bublitz
Phone: 541-768-6401
Email: **Transformation@samhealth.org**
Online: **IHNtogether.org/THW**

If we change the contact information for the THW liaison, you can find up-to-date information on our website at **IHNtogether.org/THW**.

Extra services

In lieu of services

IHN-CCO 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.

IHN-CCO offers the following:

Peer and QMHA services: Alternative setting

1) Peer and Qualified Mental Health Associate Services: Alternative Setting — A substitute for Psychosocial Rehabilitation Services. This may be good for members needing treatment for mental health or substance use services or treatment.

2) Peer and QMHA Services offered at community groups and drop in centers. These are in addition to clinical and treatment centers. Services to provide support for health and recovery in person and in group settings.

Community health worker services: Alternative setting

1) Community Health Worker Services: Alternate setting is in place of CHW Services in an office. This may be good for members needing help with managing their health and social needs.

2) CHW services offered in community spaces. Example of these spaces are schools, community centers, or your home. They can help you:

- Manage your health.
- Access housing.
- Food.
- Transportation resources.

Online diabetes self-management programs

1) Online diabetes self-management programs in place of in person diabetes self-management programs. This ILOS may be good for members 18 years and older with type 1 or type 2 diabetes.

2) Diabetes self-management programs: Support with diabetes management may be available online. These programs can provide group or individual sessions. They can help you control your blood glucose and build healthy habits.

Chronic disease self-management education programs: Alternative setting

1) Chronic disease self-management education programs: Used in place of in office chronic disease self-management education programs. This may be good for members with chronic diseases.

2) Chronic disease self-management education programs offered in community settings. There are programs for diabetes prevention and management. Also, programs for balance and fall prevention.

Infant mental health pre- and post-testing services

1) Infant mental health pre- and post-testing services in place of psychological testing. This may be good for infants at risk of not bonding. Also good for parents with risks around raising a child.

2)) Infant mental health pre- and post-testing services in addition to psychological testing — testing can be used to develop a treatment plan. This may include:

- Tests.
- Questionnaires.
- Interviews.
- Assessments that help you understand the caregiver/child relationship.

Lactation consultations: Alternative setting, alternative billing

1) Lactation consultations — alternative setting, alternative billing in place of lactation consultation in clinics. This ILOS may be good for members with babies.

2) Lactation consultations offered in community settings in addition to in a clinic. Lactation consultations can support you with breast or chest feeding your baby. They can help you decide what options are best for you.

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 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 you can call **541-768-4550** (TTY **800-735-2900**).

Health-Related services

Health-Related services (HRS) are extra services IHN-CCO 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 IHN-CCO 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. IHN-CCO Care Management team reviews requests for flexible services for if:

- The service improves health outcomes.
- Prevents avoidable hospital readmissions.
- Begin, promote, and increase wellness and health activities.
- Other options to non-Medicaid funded services.

Examples of other 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 for accessing telehealth or health apps.
- 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 Service at **541-768-4550** (TTY **800-735-2900**) and have a request form sent to you in the language or format that fits your needs.

Sometimes flexible services may be reviewed by the flexible services committee. Members and their providers will get a letter telling them about the outcome of their request. All requests are processed as quickly as the member's condition requires, most often within 10 business days, however sometimes due to the nature of the request it may take longer.

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 in section "Complaints, grievances, appeals and fair hearings."

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 **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.

IHN-CCO provides many community benefit initiatives through pilot programs. Some examples include:

- Navigation to Permanent Supportive Housing.
- Overcoming Obstacles to Dental Care.
- Culturally Responsive Peer Services.
- And many others. For more details on current IHN-CCO pilots in your area visit **IHNtogether.org/transforming-health-care**.

Examples of other community benefit initiatives are:

- Classes for parent education and family support.
- Community-based programs that help families access fresh fruits and veggies through farmers markets.
- Active transportation improvements, such as safe bicycle lanes and sidewalks.
- School-based programs that support a nurturing environment to improve students' social and emotional health and academic learning.

- Training for teachers and child-specific community-based organizations on trauma informed practices.

Health related social needs

Health related social needs (HRSN) refer to barriers to health, like housing or access to food. Please contact IHN-CCO 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 Nov. 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 March 2024.
- **Nutrition services**: Includes nutrition education, medically tailored meals, meals or pantry stocking, fruit and vegetable prescriptions. This will begin Jan. 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 health care 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 IHN-CCO. IHN-CCO 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 Management team will work with you to make sure your care plan includes the services you receive. See section “Get help organizing your care with Care Management” for Care Management 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.

Free rides to care

Getting a ride to covered services

IHN-CCO partners with Cascades West Ride Line to manage and provide all non-emergent medical transportation (NEMT) free rides to our members. Rides are covered if you are an IHN-CCO or open card members. Prior approval from Ride Line is required for reimbursement of mileage, meals and lodging to covered health services. If Ride Line is not able to provide a ride, they may pay for gas. This may be for you, a family member or friend to drive you to your visit. If you must travel overnight for approved services, Ride Line may help pay for food and lodging. IHN-CCO and Ride Line cannot send you a bill for rides to or from covered services. This is true even if payment for the ride was denied. We can help you get a ride to services that are not covered if you have care management with us.

Scheduling a ride

You can get a ride 24 hours a day, every day of the year. This service is offered at no cost to you. You can schedule a trip with Ride Line on the same day or up to 90 days before your visit. It is best to give them as much notice as possible before you need your ride. When you call, you can schedule rides for more than one visit. These multiple ride requests may also be made up to 90 days before the ride is needed. A member representative may also call and make a trip request for you. A member representative may be:

- Your community health worker.
- Foster parent.
- Adoptive parent.
- Other provider delegated with this authority.

If you need to schedule a ride, or receive prior approval for reimbursement, call Cascade West Ride Line phone at **541-924-8738**, toll free **866-724-2975** (TTY **711**) Monday through Friday, 8 a.m. to 5 p.m.

The customer service line with Ride Line offers qualified multi-lingual staff at minimum in English and Spanish. IHN-CCO offers free oral interpretation services via telephone for callers with limited English. Ride Line's call center also offers a TTY line for those who are hearing and/or speech impaired.

Ride Line call center is closed the following holidays:

- New Year's day.
- Martin Luther King Jr. day.
- President's day.
- Memorial day.
- Juneteenth.
- Independence day (also called: the Fourth of July).
- Labor day.
- Veterans day.
- Thanksgiving.
- Day after Thanksgiving.
- Christmas Eve (closed at noon).
- Christmas.

If the holidays listed falls on a Saturday, the Friday before is observed as the holiday. If the holidays listed falls on a Sunday, the following Monday is observed as a holiday.

When the call center is closed, a voice recorded answering machine will offer direct line transfers to operating dispatchers for urgent ride requests by county, at minimum, in English and Spanish. Select the county your pick-up address is located, and your call will be redirected to the driving company servicing your area. If your call is non-urgent in nature, there is an option to leave a voicemail to request a callback the next business day. Please leave a discernible message and include a valid phone number for a return call. You may also leave a message to cancel a ride request. The call center has dedicated staff that will return your call the next business day. If your ride request is emergent in nature, please call 911.

For Ride Line to choose the best service that meets your needs, they will ask you questions. Please be ready to answer the following when you call to schedule a ride:

- Your name.
- Your date of birth.
- Your address.
- Your preferred method and time of contact (phone, email, fax).
- Doctor or facility name.
- Doctor or facility address.
- Doctor or facility phone number.
- Date of your scheduled visit.
- Time of your scheduled visit.
- Pick up time after visit.
- Medical reason for visit (to confirm coverage).
- Level of mobility (walker, wheelchair, scooter).
- Functional independence (a physical or behavioral health disability that may require a personal care attendant, service animal, a secure transport, etc.).
- Any specific directions to your home or medical facility.

Ride Line is responsible for confirming rides with their drivers. Acceptable modifications to your trip request may be made to deliver the most cost-effective transport, but that also is appropriate to meet your needs. You will receive written notification of any modifications made to your NEMT service. Reasonable modifications include, but are not limited to, requiring you to:

- Use a specific transportation provider.
- Travel with an attendant.
- Use public transportation where available.
- Drive or locate someone to drive you and receive reimbursement.
- Confirm the ride with the NEMT provider on the day of or the day before the scheduled ride.

It may be needed for Ride Line to provide secure transport. Secure transport means a safe vehicle equipped with restraints to help with individuals having a crisis. This might include exhibiting signs and symptoms of wanting to harm themselves or those around them. Secure transports will take a member to an in-network facility that is able to treat your medical or behavioral health needs during crisis. One extra attendant may go with the member at no charge when medically needed. An example of when it might be needed is to give medications in-route or to satisfy legal requirements including, but not limited to, when a parent, legal guardian or escort is required during transport. Remember, call to cancel if plans change and you no longer need a ride.

Eligibility

Your answers to the questions above will be used to see if you qualify for rides. Ride Line will note trip information within their system within 24 hours. This will allow Ride Line to approve and schedule or deny a request for NEMT services (including all legs of the trip). This time will be reduced as needed to ensure the member arrives in time for their appointment. Confirmation details will be given during your request call. These details will be given no less than two (2) days prior to the scheduled pick up time. Ride Line is not responsible for making arrangements for the use of public transportation and mileage reimbursement requests. This applies to reimbursement requests through the use of Lyft, Uber, driving yourself or finding a ride from a friend. If you schedule a pick up less than two (2) days before the scheduled pick-up time, they will give you the details at the time of the request. They will also call you the day before your scheduled trip. These details will include:

- Your transport's name (the driving company assigned to transport you).
- The driver's name and phone number.

- Your pick-up date and time.
- Pick-up address.
- The name of your provider.
- The address of the provider's office.

Eligibility for a ride will be verified by:

- Checking enrollment status with the CCO and that you are eligible for services.
- Checking if your services are a covered OHP service or a Health-Related Service.
- Checking if the provider offering the services accepts IHN-CCO members.
- Making sure these services cannot be offered by a provider within our service area. If services are not offered by a provider in our service area, your trip is eligible for out of area providers.
- Checking that the transportation type is a covered NEMT service.

If you are a full benefit dual eligible member, Ride Line will make sure you have coverage with IHN-CCO. FBDE members can also get rides to Medicare covered services.

If you are enrolled in the Compact of Free Association (COFA) or the Veteran Dental Program, Ride Line will only offer rides related to your dental services.

Ride Line services

Ride Line will choose the best service to meet your needs. These services include the type of ride and the level of driver support. The following types of services are covered:

- Reimbursement.*
- Sedan.
- Wheelchair.
- Stretcher.
- Secure transport.
- Dial-a-Ride, Greyhound and Amtrak.
- Plane fare.*
- Food and lodging.*
- Driver will meet you at the curb of your pickup location.
- Driver support walking up and down one or two stairs.
- Driver support walking from your door to the vehicle.
- Driver support walking from the vehicle to the facility lobby.
- Type of trip requires prior approval from Ride Line.

Once approved by Ride Line, your trip will be given to a transport driver that meets your needs. On the day of your scheduled trip, their drivers may come to your door or the main entrance of the medical building. This is to let you know they are ready to transport you. Ride Line drivers may help you into the main lobby but will not go further into the building. If you need more help, you will need to bring someone to help you.

Service changes may be made to ensure you and the driver are safe. Changes to your service may happen when you:

- Have a medical condition that presents a direct threat to the driver or others in the vehicle.
- Threaten harm to the driver or others in the vehicle or create circumstances that put the driver or others in the vehicle at risk of harm.

Engage in behavior that, in the CCO's opinion, causes local medical providers or facilities to refuse to provide further services without modifying NEMT services in order to ensure providers will provide the covered services to you.

- Often cancel or do not show up for the scheduled Ride Line services.
  Have a special condition that includes physical or behavioral health disabilities.

Changes to your services may be made to make sure that your covered service is carried out, despite any events that might come up that are out of our control. Ride Line will use their best judgement and will contact IHN-CCO if needed.

At the very least, drivers will offer the approved level of help that is needed and has been approved. Examples of this are curb-to-curb, door-to-door, or hand-to-hand help.

Ride Line drivers are not allowed to do the following:

- Enter your home or hospital room (except for hospital discharge).
- Help you get ready for the trip (such as getting dressed).
- Help you from bed to wheelchair, or wheelchair to van.
- Change scheduled pick up times without written permission from Ride Line.
- Help you with any personal needs during your rides.
- Ask for or accept fares or tips.
- Ask for or sell any products or services.
- Make extra stops or run errands.

Reimbursement details

If you need to schedule a ride, or receive prior approval for reimbursement, call: Cascade West Ride Line Phone at **541-924-8738**, toll free **866-724-2975** (TTY **711**) Monday through Friday, 8 a.m. to 5 p.m.

Reimbursement for mileage, meals and lodging to covered health services requires prior approval from Ride Line. call Ride Line customer service for more reimbursement information.

A packet will be mailed to you or made available for pick up. To get paid back for a ride, extra information is required. Your providers signature, from your appointment, is needed. All documentation must be returned to Ride Line before you will get reimbursed.

Ride Line may deny your request to be reimbursed if Ride Line gets your request more than 45 days after the trip happened. Rates for mileage, meals and lodging are set by the Oregon Health Authority. The table has the rates provided by OHA.

Reimbursement rates

Service type	Reimbursement rate	Special considerations
Private car mileage	$0.44 per mile	NA
Client meals Attendant meals	$27 per day $27 per day	NA
Breakfast for client Breakfast for attendant	$6.50 $6.50	Travel begins before 6 a.m.
Lunch for client Lunch for attendant	$7.50 $7.50	Travel must span the entire period from 11:30 a.m. to 1:30 p.m.
Dinner for client Dinner for attendant	$13 $13	Travel ends after 6:30 p.m.

Client lodging Attendant lodging	$98 per night $98 per night	The attendant lodging reimbursement only qualifies **IF** the attendant is staying in a separate room from the client.

Ride Line may hold your reimbursement under the amount of $10 until your amount is equal to or more than $10.

Ride Line must reimbursement for meals when you travel:

- Out of your local area.
- 30 miles or 30 minutes in urban areas.
- 60 miles or 60 minutes in rural areas.
- For a minimum of four hours- round trip.

Ride Line must reimburse for overnight stay (lodging) when:

- Travel before 5 a.m. would be required to reach your scheduled appointment.
- Your trip back from a scheduled appointment would happen after 9 p.m.
- Your provider documents a medical need.

Ride Line may reimburse you for lodging under additional circumstances after careful review and consideration with IHN-CCO.
Ride Line must reimburse for meals and lodging for one attendant, which may be a parent, to go with the Member if medically necessary. One attendant may be reimbursed if any of the following apply:

- The member is a minor child and unable to travel without an attendant.
- Your attending provider provides a signed statement indicating the reason an attendant must travel with you.
- You are mentally or physically unable to reach their medical appointment without assistance.
- You would be unable to return home without assistance after the treatment or service.

Ride Line may reimburse for meals and lodging for additional attendants or under additional circumstances after careful review and consideration with IHN-CCO.

In some cases there may be more than one group that has reimbursed your NEMT travel. If this happens, Ride Line of IHN-CCO may recover overpayments made to you. Overpayments happen when Ride Line, IHN-CCO or other transportation company paid the member:

- For the ride, meal or lodging and another source already paid:
    - The member.
    - The ride, meal or lodging provider directly.

To travel directly to an appointment, but:

- You did not use the money for your appointment.
- You did not attend your appointment.
- You shared your ride with another member who was also reimbursed.
- You were reimbursed for public transportation tickets but you sold or gave your tickets/passes to someone else.

If someone or something other than yourself (or parent/guardian if the member is a minor) provides the ride, Ride Line may reimburse that person or entity directly.

Personal care attendant

A personal care attendant must go with you if you are not able to travel by yourself to your visits. You must provide your own personal care attendant. One personal care attendant can travel with you at no cost. Your personal care attendant must accompany you from your pick up location to the destination and then on the return trip. Ride Line only provides the ride and does not pay for wages, meals or other costs for your personal care attendant. Extra riders may have to pay a fare or a shared ride cost.

Children 12 years of age and younger and members with special physical and development needs must have one adult attendant with them at all times. Ride Line will determine if you require assistance and if the attendant meets the requirement for an attendant. This adult (18 years or older) can go with the member at no cost and may be:

- The child's parent or legal guardian.
- An adult relative.
- An adult expressly identified in writing by the parent or legal guardian as an attendant.
- A Department of Human Services employee or volunteer.

Children 13 years of age and older do not need an adult with them to use Ride Line. One adult may still travel with children under age 18 at no cost. Doctors may need an adult to give consent and be present for children under 18 to get care.

Ride Line is not able to supply specialty safety seats. Your personal care attendant shall provide and install safety seats based on your needs. Ride Line is unable to complete the ride request if the appropriate safety seat is not provided. Children weighing less than 40 pounds and who are four feet nine inches or shorter must be properly secured in a safety seat and installed by the adult attendant. If the individual weighs more than 40 pounds and who are four feet nine inches or shorter must also be properly secured in appropriate safety belt, harnesses or child safety system that meet all State laws. Children under two (2) years of age must be properly secured with a child safety system in a rear-facing position.

Pick up and drop off

Ride Line will make sure that the scheduled pick up time shall allow for travel time that will get you to your appointment on time. You will be picked up from your visit, at the scheduled time, if you scheduled a return time. If you did not schedule a return pick up time, you will need to call Ride Line. A driver will arrive within one hour of your call.

Details to know about your pick up and drop off:

- Drivers will let you know when they arrive.
- Drivers must wait for you for 15 minutes past your scheduled pick up time before leaving. The driver will leave if you are not in the car within 15 minutes of your pick up time. The driver will notify Ride Line before leaving.
- They may arrive earlier than your scheduled pick up time. You do not have to get into the car before your scheduled time.
- You will be dropped off at least 15 minutes before your scheduled visit. This will keep you from being late to your visit.
- Drivers will not drop you off more than one hour before your scheduled visit.
- Drivers are not allowed to drop you off for your visit more than 15 minutes before the facility opens or within 15 minutes of the facility closing. You, a guardian, a parent or a representative may request a different amount of time.

- Drivers will not drop off a member more than 15 minutes of their appointment starting.
- Drivers are not allowed to pick you up from your visit more than 15 minutes after the facility closes.
- Drivers will not drop you off at a facility that is closed.

Delays and unplanned schedule changes

Ride Line has contact with their drivers and will send cars as needed. If a driver has not arrived within 15 minutes from a scheduled pick up time, Ride Line will send another car. They will help you make it to your visit on time.

Ride Line has a way to handle unplanned schedule changes. This may happen when there is a high volume of rides scheduled. Ride Line may send another driver to help you get to your scheduled pick up or drop off site. Drivers will not change your scheduled pick up time without prior written permission from Ride Line.

The assigned driving company will provide updated information to drivers, monitor drivers' locations and solve pick up and drop off issues.

In case of bad weather

Ride Line puts the safety of you and their drivers first. If our area is having extreme weather that will affect your trip needs, someone will call you. Extreme weather includes:

- High heat.
- Extreme cold.
- Flooding.
- Heavy snowfall.
- Icy roads.
- Tornado warnings.
- Some other conditions.

Each car has a working air conditioner and heater. All cars also have snow chains. If bad weather prevents a driver from getting to you, Ride Line will call to cancel your trip.

If you need critical care, such as chemo or dialysis, Ride Line will call the facility. If it is open, Ride Line will send a driver. If it is closed, Ride Line will not send a driver. They will tell you to call **911**.

Ride Line customer service staff are trained to assist with your trip needs. This includes changes due to bad weather. Call Ride Line if you have questions or concerns about your ride.

Monitoring and documenting

IHN-CCO and Ride Line must keep all information necessary to give rides, including:

- The ride details.
- Your member ID.
- The pick up and drop off details.
- The reason for the ride.
- If you or your driver does not show up for the ride.
- Payment details of the ride.
- Complaint details.

Ride Line obeys the law to keep your information safe. All your information is kept private. Ride Line will only tell the driver the details needed to give you your ride. This includes medical details, such as

if you use oxygen. Drivers will not share any of your information outside of the ride (unless required) except with:

- Ride Line.
- IHN-CCO.
- Oregon Health Authority.
- Oregon Department of Human Services.

IHN-CCO and Ride Line also ensure that all Ride Line cars and drivers meet the requirements found in the Oregon law. This law is called Vehicle Equipment and Driver Standards. All vehicles shall include, without limitation, the following safety equipment:

- First aid kit.
- Fire extinguisher.
- Roadside reflective or warning devices.
- Flashlight.
- Tire traction devices (when needed).
- Disposable gloves.

All equipment necessary to securely transport members using wheelchairs or stretchers in accordance with the Americans with Disabilities Act of 1990 (ADA), Section 405 of the Rehabilitation Act of 1973 and Oregon Revised Statute 659A.103.

Drivers must meet all requirements in this law, such as:

- Complete all required pre-employment screenings such as screening for any exclusions from participating in any federal programs.
- A verified Oregon driver's license with any required endorsements
- Pass required background checks.

Cars must maintain safety and comfort standards, such as:

- Have safety belts.
- Have fire extinguishers.
- Have first aid kits.
- Be smoke, aerosol and vape free.
- Be clean and free of trash.

A maintenance schedule will be followed for each vehicle that includes the maintenance that the vehicle manufacturer suggests. The vehicle must be in good working condition and shall include, but is not limited to, the following:

- Side and rearview mirrors.
- Horn.
- Heating, air conditioning and ventilation systems.
- Working turn signals, headlights, taillights and windshield wipers.

For more details, call Ride Line customer service at **541-924-8738**, toll free **866-724-2975** (TTY **711**).

Accidents and incidents

Ride Line shall inform IHN-CCO right away of any accidents and incidents. They need to be told when the driver or passenger are injured or there was a death. They also need to be told if there has been any abuse or alleged abuse by the driver during the ride.

We will submit a written accident or incident report to OHA. A copy of the police report will be sent when one is ready. This will take place within two business days of the accident or incident after we have been informed. We will help in any related inquiry.

The following information must be collected for reporting:

- The name of the driver.
- The name of the passenger.
- The location of the incident.
- The date and time of the incident.
- A description of the incident.
- Any injuries resulting from the incident.
- Whether the driver or passenger needed treatment at a hospital.

Member rights and responsibilities

Passenger rights:

- Get safe and reliable transportation services that meet your needs.
- Ask for interpretation services when talking to Customer Service and request materials in a language or format that meets your needs.
- File a grievance about your ride experience.
- Submit an appeal, ask for a hearing or ask for both if you feel you have been denied a service unfairly.
- Get a written notice when a ride is denied.
- To ensure you have a quality trip, our drivers will treat you and other passengers with respect and dignity.

Passenger responsibilities:

- Treat drivers and other passengers with respect.
- Call Ride Line as early as possible to schedule, change or cancel your transportation. At minimum an hour prior to your pickup time would be appreciated by driver staff.
- Use seat belts and other safety equipment as required by Oregon law.
- Ask for additional stops in advance. If you need to make a stop at a pharmacy or other location, we must approve that.
- Be ready at the scheduled time of your trip.
- Tell your providers about trip information to your doctors front office staff so that Ride Line may request end of appointment timeframe from the front office staff without the hurdle of HIPPA.

IHN-CCO has a process for documenting, responding to and addressing or resolving all grievances. You have the right to file a grievance with both Ride Line and IHN-CCO. Reasons you can file a grievance include but are not limited to:

- Driver or car safety.
- Quality of service.
- Interactions with providers and drivers (ex. rudeness).
- Access to service.
- Consumer rights.

If you need to file a complaint about being denied services (in full or in part), you may file an appeal with us. We will work with Ride Line to review the request.

There is no limit to how many times you can file a complaint. Neither Ride Line nor IHN-CCO can stop you from filing a complaint, even if you already filed the same complaint.

Ride Line and IHN-CCO will log, respond to and address your complaints. If your complaint includes a driver who did not show up for a scheduled ride, Ride Line will call you for follow up. Required follow up will include asking you:

- If you were harmed by missing your visit.
- Whether you need or needed to reschedule your visit.

You have the right to appeal if you are denied a ride to a visit. Before your denial is final, there will be a second review of your request. Ride Line will let you know about the denial at the time of the request. We will send you a letter within 72 hours. The letter will be mailed to you and to the provider where the visit was scheduled. This will happen as long as the provider is within the network and requested the transportation on the member's behalf.

IHN-CCO, Ride Line nor the drivers may bill you, a member, for transport to or from a covered service. This is true even if a denial of reimbursement for the transport was issued.

Ride Line, the associated driving companies, and the drivers cannot stop you from filing a grievance or appeal, cannot encourage you to withdraw your grievance or appeal, and cannot use your grievance or appeal against you.

For more details about your rights to file a grievance or appeal, please see the Grievance system information and appeal rights.

For more details about getting a ride, go to **IHNtogether.org/Transportation**.

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. IHN-CCO will cover telehealth visits. Telehealth lets you visit your provider using a:

- Phone (audio).
- Smart phone (audio/video).
- Tablet (audio/video).
- Computer (audio/video).

If you do not have internet or video access, talk to your provider about what will work for you.

How to find telehealth providers

Not all providers have telehealth options. You should ask about telehealth when you call to make your appointment.

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

When to use telehealth

IHN-CCO 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 “Hospitals” section for a list of hospitals with emergency rooms.

If you do not know what telehealth services or options your provider has, call them and ask.

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) in the “We keep your information private” section.

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 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 in the “You can have an interpreter” section.
- Get in-person visits, not just telehealth visits.
    - IHN-CCO 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.
    - IHN-CCO will help identify what telehealth tool is best for you.

Talk to your provider about telehealth. You can also call Customer Service at **541-768-4550** (TTY **800-735-2900**).We are open Monday through Friday, 8 a.m. to 8: p.m.

Prescription medications

To fill a prescription, you can go to any pharmacy in IHN-CCO’s network. You can find a list of pharmacies we work with in our provider directory at **IHNtogether.org/FindCare.**

For all prescriptions covered by IHN-CCO, bring to the pharmacy:

- The prescription.
- Your IHN-CCO 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

IHN-CCO list of covered medications is at **IHNtogether.org/Prescriptions**.

- 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.

- IHN-CCO 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.

IHN-CCO 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 IHN-CCO to cover prescriptions

When your provider asks IHN-CCO to approve or cover a prescription:

- Doctors and pharmacists at IHN-CCO 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 IHN-CCO decides to not cover the prescription, you will get a letter from IHN-CCO. 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 IHN-CCO Pharmacy Customer Service at **541-768-4550** (TTY **800-735-2900**) if you have questions.

Mail-order pharmacy

We have some in-network pharmacies that will mail your drugs to you. Please review the list of pharmacies on our website at **IHNtogether.org/Prescriptions**. 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 IHN-CCO Customer Service at **541-768-4550** (TTY **800-735-2900**) to learn more about mail-order pharmacy.

OHP pays for behavioral health medications

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

- IHN-CCO and your provider will help you get the medications you need.
- The pharmacy sends your prescription bill directly to OHP. IHN-CCO 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 IHN-CCO Customer Service at **541-768-4550** (TTY **800-735-2900**).

Prescription coverage for members with Medicare

IHN-CCO 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 IHN-CCO ID card at the pharmacy.

If Medicare Part D does not cover your medication, your pharmacy can bill IHN-CCO. If OHP covers the medication , IHN-CCO will pay for it.

Learn more about Medicare benefits in section “Members with Medicare”.

Getting prescriptions 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 IHN-CCO at **541-768-4550** (TTY **800-735-2900**) to find out if this is a good option for you.

Hospitals

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

Albany

Samaritan Albany General Hospital
1046 6th Ave. SW, Albany, OR 97321
541-812-4000 (TTY **800-735-2900**)
samhealth.org/Albany

Corvallis

Good Samaritan Regional Medical Center
3600 NW Samaritan Dr., Corvallis, OR 97330
541-768-5111 (TTY **800-735-2900**)
samhealth.org/Corvallis

Lebanon

Samaritan Lebanon Community Hospital
525 N Santiam Highway, Lebanon, OR 97355
541-258-2101 (TTY **800-735-2900**)
samhealth.org/Lebanon

Lincoln City

Samaritan North Lincoln Hospital
3043 NE 28th St., Lincoln City, OR 97367
541-994-3661 (TTY **800-735-2900**)
samhealth.org/LincolnCity

Newport

Samaritan Pacific Communities Hospital
930 SW Abbey St., Newport, OR 97365
541-265-2244 (TTY **800-735-2900**)
samhealth.org/Newport

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, seven 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). If you don't know if your problem is urgent, still call your provider's office, even if it's closed.

You can call anytime, day or night, on weekends and holidays. Tell the PCP office you are a IHN-CCO member. You will get advice or a referral. See section "Provider directory" for more information. 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 IHN-CCO Customer Service at **541-768-4550** (TTY **800-735-2900**).

If you do not know your provider's phone number you can access it here in the provider directory **IHNtogether.org/FindCare**. When you call you may get an answering service. Leave a message and say you are a IHN-CCO member. You may get advice or a referral of somewhere else to call. You will get a call back from a IHN-CCO representative within 30-60 minutes after you called, to talk about next steps.

IHN-CCO also offers a Nurse Advice Line. When you have health questions, the Nurse Advice Line is available 24/7 to help you. The nurse advice line can help you:

- Understand why you're feeling the way you do.
- Decide the best place to go for care.
- Learn more about what your provider has said about your health.
- Explore your care options.
- Learn about the drugs your provider wants you to take.

Call the nurse advice line toll free at **844-219-3816** or TTY users call **800-735-2900**.

For emergencies, call **911** immediately.

For non-urgent advice and appointments, please call during business hours.

Urgent care centers and walk-in clinics in the IHN-CCO area:

Albany

Samaritan Urgent Care Walk-In Clinic — Geary Street
1700 Geary St. SE, Albany, OR 97322
541-812-5500 (TTY **800-735-2900**)
Monday through Friday: 9 a.m. to 8 p.m.
Saturday: 9 a.m. to 6 p.m.
Sunday: 9 a.m. to 5 p.m.

Corvallis

Samaritan Urgent Care Walk-In Clinic — Corvallis
5234 SW Philomath Blvd., Corvallis, OR 97333
541-768-4970 (TTY **800-735-2900**)
Monday through Friday: 9 a.m. to 8 p.m.
Saturday: 9 a.m. to 6 p.m.
Sunday: 9 a.m. to 5 p.m.

SamCare Express — Corvallis
850 SW 26th St, Corvallis, OR 97331
541-768-5166 (TTY **800-735-2900**)
Monday through Friday: 7 a.m. to 6 p.m.
Saturday: 9 a.m. to 6 p.m.
Sunday: 9 a.m. to 5 p.m.

The Corvallis Clinic Immediate Care
3680 NW Samaritan Drive, Corvallis, OR 97330
541-754-1282 (TTY **800-735-2900**)
Monday through Friday: 8 a.m. to 7 p.m.
Saturday through Sunday: 10 a.m. to 5 p.m.

Depoe Bay

Samaritan Depoe Bay Clinic

531 N Highway 101, Suite A, Depoe Bay, OR 97341
541-765-3265 (TTY **800-735-2900**)
Monday through Friday: 8 a.m. to 6 p.m.

Lebanon

Samaritan Urgent Care Walk-In Clinic — Lebanon
35 Mullins Drive, Suite 2, Lebanon, OR 97355
541-451-7915 (TTY **800-735-2900**)
Monday through Friday: 9 a.m. to 8 p.m.
Saturday: 9 a.m. to 6 p.m.
Sunday: 9 a.m. to 5 p.m.

Lincoln City

Samaritan Coastal Clinic
825 NW Highway 101, Suite A, Lincoln City, OR 97367
541-996-7480 (TTY **800-735-2900**)
Monday through Friday: 8 a.m. to 1:00 p.m., 2:00 p.m. to 8 p.m.
Saturday and Sunday: 9 a.m. to 1:00 p.m., 2:00 p.m. to 6 p.m.

Newport

Samaritan Pacific Walk-In Clinic
930 SW Abbey St., Newport, OR 97365
541-574-4860 (TTY **800-735-2900**)
Monday through Friday: 9 a.m. to 6:30 p.m.
Saturday and Sunday: 9 a.m. to 5:30 p.m.

Sweet Home

Sweet Home Family Medicine
679 Main St., Sweet Home, OR 97386
541-451-6250 (TTY **800-735-2900**)
Monday through Friday: 7:30 a.m. to 5:30 p.m.
Sunday 9 a.m. to 5:30 p.m.

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 Dental Customer Service at **541-768-4550** (TTY **800-735-2900**). They will help you find urgent dental care, depending on your condition. You should get an appointment within two weeks or one 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 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.
You can get urgent and emergency services 24 hours a day, seven 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 IHN-CCO Customer Service within three 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.

See a list of hospitals with emergency rooms in section “Hospitals”.

Dental emergencies

A dental emergency is when you need same-day dental care. This care is available 24 hours a day and seven 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.

For a dental emergency, please call your primary care dentist (PCD). You will be seen within 24 hours. Some offices have emergency walk-in times. If you cannot reach your PCD or you do not have one, call Customer Service at **541-768-4550** (TTY **800-735-2900**). They will help you find emergency dental care.

If none of these options work for you, call **911** or visit the Emergency Room**. If you need an ambulance ride, please call 911.** See a list of hospitals with emergency rooms in section “Hospitals”.

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. IHN-CCO 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.

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

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, seven days a week.

If you have a mental health emergency

Call a 24/7 crisis hotline:

Benton County: 888-232-7192

Lincoln County: 866-266-0288

Linn County: 866-266-0288

— or —

Call 911

Respite (relief) services

We work with the following programs to provide relief services:

- **Janus House** — Helps members of our community who are at risk of going to the hospital due to behavioral health crises.
- **Jasper Mountain SAFE Center** — Helps to give short term respite for youth IHN-CCO members.
- **Morrison Child and Family Services** — Helps provide respite through certified foster homes for youth ages 2 to 17 in Benton, Lincoln and Linn counties.

A behavioral health crisis is when you 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.

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

- Considering suicide.
- 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.

Here are some things IHN-CCO 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 above).
- 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, seven 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 in section “Behavioral health care benefits”.

Suicide prevention

If you have a mental illness and do not treat it, you may risk suicide. With the right treatment, your life can get better.

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:

988 Suicide and Crisis Lifeline

The **988 Suicide and Crisis Lifeline** is available 24 hours a day, seven days a week, every day of the year. It is for people having a behavioral health crisis. You can call, text or chat online at **988lifeline.org**. Calls may be answered in English or Spanish. Text and online chat are currently only available in English.

People can also dial **988** if they are worried about a loved one who may need crisis support. The 988 Suicide and Crisis Lifeline is easy to remember, like **911**. It offers a direct link to trained crisis counselors who will offer care and support for anyone experiencing mental health-related distress. This includes thoughts of suicide or self-harm, a substance use crisis or any other kind of behavioral health crisis. The counselor is part of a call center that is linked to a network of services, so the caller will be connected quickly with the right kind of help, from the right type of helper.

Follow-up care after an emergency

After an emergency, you may need follow-up care. 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.

Care away from home

Planned care out of state

IHN-CCO 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 section “Getting prescriptions before a trip”.

You may need emergency care when away from home or outside of the IHN-CCO 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, IHN-CCO is not allowed to pay you back. See section “If your provider sends you a bill, do not pay it.” 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 Plan ID card and IHN-CCO ID card with you when you travel out of state.

2. Show them your IHN-CCO ID Card and ask them to bill IHN-CCO.

3. Do not sign any paperwork until you know the provider will bill IHN-CCO. Sometimes IHN-CCO cannot pay your bill if an agreement to pay form has been signed. To learn more about this form see section “You may be asked to sign an Agreement to Pay form”.

4. You can ask that the Emergency Room or provider’s billing office to contact IHN-CCO if they want to verify your insurance or have any questions.

5. If you need advice on what to do or need non-emergency care away from home, call IHN-CCO 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 IHN-CCO can cover. IHN-CCO 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 IHN-CCO. 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 IHN-CCO in-network provider (for a list of in-network providers see section “Provider directory”) 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 IHN-CCO for services you are not responsible for to the contracted provider.

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 IHN-CCO 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 Service **541-768-4550** (TTY **800-735-2900**). For more information about surprise billing go to **oregon.gov/Documents/Surprise-billing-consumers.pdf**.

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

Call IHN-CCO for help right away at **541-768-4550** (TTY **800-735-2900**).

You can also call your provider’s billing office and make sure they know you have OHP.

There may be services you have to pay for

Usually, with IHN-CCO, 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 IHN-CCO 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 IHN-CCO, another insurance or gave a name that did not match the one on the IHN-CCO ID at the time of or after the service was provided, so the provider could not bill IHN-CCO. Providers must verify your IHN-CCO 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 IHN-CCO you may have to pay for your services. Before you see a provider that is not in-network with IHN-CCO you should call Customer Service 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 section "Provider directory".
- **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 IHN-CCO. 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 below.
    - Always contact IHN-CCO Customer Service first to discuss what is covered. If you get a bill, please contact IHN-CCO Customer Service 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 IHN-CCO Customer Service at **541-768-4550** (TTY **800-735-2900**).

You may be asked to sign an Agreement to Pay form

An agreement to pay form is used when you want a service that is not covered by IHN-CCO or OHP. The form is also called a waiver. You can see a copy of the form at **sharedsystems.dhsoha.state.or.us/DHSForms/Served/he3165.pdf** .

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 IHN-CCO would pay them in full for the covered service.
    - The estimated cost, including all related charges, the amount IHN-CCO would pay for the service. The provider cannot bill you for an amount more than IHN-CCO would pay.
    - 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:
    - 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 IHN-CCO 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 IHN-CCO Customer Service 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:

- Do not ignore medical bills.
- Contact IHN-CCO Customer Service as soon as possible at **541-768-4550** (TTY **800-735-2900**), Monday through Friday, 8 a.m. to 8 p.m.
- 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 IHN-CCO, contact Customer Service. Learn more about denials, your right to an appeal, and what to do if you disagree with us in the "Complaints, grievances, appeals and fair hearings" section.
    - You can also appeal by sending IHN-CCO 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 Service 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 IHN-CCO.
- IHN-CCO pays for all covered services in accordance with the Prioritized List of Health Services, see section "Your benefits".
- For a brief list of benefits and services that are covered under your OHP benefits with IHN-CCO, who also covers case management and care coordination, see section "Your benefits". If you have any questions about what is covered, you can ask your PCP or call IHN-CCO customer service.
- No IHN-CCO 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 IHN-CCO for services you are not responsible for.
- Members are never charged for rides to covered appointments. See section "Free rides to care". 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 IHN-CCO 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 section “Learn more about the steps to ask for an appeal or hearing”.

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:

- Copays.
- Deductibles.
- 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 Service 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 IHN-CCO.
IHN-CCO 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 IHN-CCO. If they still say you owe money, call Customer Service at **541-768-4550** (TTY **800-735-2900**).

- Give the provider your OHP ID number and tell them you’re covered by IHN-CCO. If they still say you owe money, call Customer Service at **541-768-4550** (TTY **800-735-2900**). We can help you.
- Learn about the few times a provider can send you a bill in section “There may be services you have to pay for“.

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 when you can change or leave a CCO.

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.

Members with Medicare and OHP (Medicaid) 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 who 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.

Service areas with only one CCO: Members with only one CCO in their service area may ask to disenroll (leave) a CCO and get care from 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.
- You're at risk of having a lack of continued care.

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**.

Service areas with more than one CCO:

Members with more than one CCO in their service area may ask to leave and change a CCO at any time for any of the following "with cause" reasons:

- You move out of the service area.
    - 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**.
- The CCO has moral or religious objections 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.
- You're at risk of having a lack of continued care.

Members with more than one CCO in their service area may also ask to leave and change a CCO at any time for the following "without cause" reasons:

- Within 30 days of enrollment if:
    - You don't want the plan you were enrolled in.
    - You asked for a certain plan and the state put you in a different one.
- In the first 90 days after you join OHP:
    - If the state sends you a "coverage" letter that says you are part of the CCO after your start date, then you have 90 days after that letter date.
- After you have been with the same CCO for 6 months.

- When you renew your OHP.
- If you lose OHP for less than 2 months, are reenrolled into a CCO, and missed your chance to pick the CCO when you would have renewed your OHP.
- When a CCO is suspended from adding new members.
- At least once every 12 months if the options above don't apply.

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**.

How to change or leave your CCO

Things to consider: IHN-CCO wants to make sure you receive the best possible care. IHN-CCO 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 IHN-CCO.

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 and/or your representative can call OHP Customer Service at **800-699-9075** or **800-273-0557** (TTY **711**), 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**.

You can get care while you change your CCO. See section "When you need the same care when changing plans" to learn more.

IHN-CCO can ask you to leave for some reasons

IHN-CCO 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 IHN-CCO staff. When the act or threat of violence seriously impairs IHN-CCO 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 section "Complaints, grievances, appeals and fair hearing" for how to make a complaint or ask for an appeal.

IHN-CCO 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 IHN-CCO disagrees with.

For more information or questions about other reasons you may be disenrolled, temporary enrollment exceptions or enrollment exemptions, call IHN-CCO at **541-768-4550** (TTY **800-735-2900**) 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:

- End-stage renal disease care.
- You're a medically fragile child.
- Receiving breast and/or cervical cancer treatment program members.
- Receiving Care Assist help due to HIV/AIDS.
- Post-transplant care.
- You're pregnant or just had a baby.
- 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 IHN-CCO, 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 IHN-CCO Customer Service at:**541-768-4550** (TTY **800-735-2900**), Monday through Friday, 8 a.m. to 8 p.m.

IHN-CCO 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 IHN-CCO network until one of these happen:
    - The minimum or approved prescribed treatment course is completed.
    - 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 IHN-CCO Transition of Care Policy by calling Customer Service at **541-768-4550** (TTY **800-735-2900**) . It is also on our website on the Transition of Care section at **IHNtogether.org/MembersRights**. Please call Customer Service 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**. The advance directive can be found here **IHNtogether.org/Advance-Directive**.

See **IHNtogether.org/Health-Resources** for more details.

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 pamphlet on advance directives. It is called “Advance directives. Your care is your decision”. Just call us to learn more, get a copy of the pamphlet and the Advance Directive form. Call IHN-CCO Customer Service at **541-768-4550** (TTY **800-735-2900**) .

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 Advance Directive form, please visit **oregon.gov/oha/ph/about/pages/adac-forms.aspx**.

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 IHN-CCO 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.
- IHN-CCO will honor any choices you have listed in your completed and signed Advance Directive.

How to complain if IHN-CCO 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
503-370-9216 (TTY **711**)
Hours: Monday through Friday, 8 a.m. to 5 p.m.
Mail a complaint to:
1430 Tandem Ave NE, Ste. 180
Salem, OR 97301
Email: **hlo.info@odhsoha.oregon.gov**

Call IHN-CCO Customer Service at **541-768-4550** (TTY **800-735-2900**) to get a paper copy of the complaint form.

You can find complaint forms and learn more at **oregon.gov/oha/PH/HLO/Pages/File-Complaint.aspx**.

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**, **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 health care provider.
When is it used?	Future care or condition.	Current care and condition.

To learn more, visit **oregonpolst.org**. Email **polst@ohsu.edu** or call Oregon POLST at **503-494-3965**.

Declaration for mental health treatment

Oregon has a form for writing down your wishes for mental health care. 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 three years. If you become unable to decide during those three 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 **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 **oregon.gov/OHA/PH/ProviderPartnerResources/HealthcareProvidersFacilities/HealthcareHealthCareRegulationQualityImprovement/Pages/index.aspx**. Send your complaint to:

Health Care Regulation and Quality Improvement
800 N.E. Oregon St., #465
Portland, OR 97232
Email: Mailbox.HCLC@odhsoha.oregon.gov
Phone: **971-673-0540** (TTY **971-673-0372**)
Fax: 971-673-0556

Reporting fraud, waste and abuse

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

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

Medicaid Fraud is against the law and IHN-CCO takes this seriously.

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

- A provider charging you for a service covered by IHN-CCO.
- 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.

IHN-CCO 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

You can make a report of fraud, waste and abuse a few ways:
Call, fax, submit online or write directly to IHN-CCO. **We report all suspected fraud, waste and abuse committed by providers or members to the state agencies listed below.**

InterCommunity Health Network (IHN)
Mail: Compliance Department
Samaritan Health Plans
2300 NW Walnut Blvd.
Corvallis, OR 97330
Call: Customer Service at 541-768-4550 (TTY **800-735-2900**) and ask to speak to the Compliance Officer.
Fax: 541-768-9791
Email: SHPOCompliance@samhealth.org

OR

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

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

OR (specific to providers)

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

OR

Medicaid Fraud Control Unit (MFCU)
Oregon Department of Justice
100 SW Market St.
Portland, OR 97201

Phone: **971-673-1880**
Fax: 971-673-1890

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

Complaints, grievances, appeals and fair hearings

IHN-CCO 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.

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:

IHN-CCO Customer Service
541-768-4550, toll free **800-832-4580** (TTY **800-735-2900**)
Monday through Friday: 8 a.m. to 8 p.m.
Visit us:
2300 NW Walnut Blvd., Corvallis, OR 97330
Monday through Friday: 8 a.m. to 5 p.m.

You can make a complaint

- A **complaint** is letting us know you are not satisfied.
- A **dispute** is when you do not agree with IHN-CCO or a provider.
- A **grievance** is a complaint you can make if you are not happy with IHN-CCO, your health care 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 Service at **800-832-4580** (TTY **800-735-2900**). You can also make a complaint with OHA or Ombuds. You can reach OHA at **800-273-0557** or Ombuds at **877-642-0450** or write:

IHN-CCO Appeals and grievances
PO Box 1310, Corvallis, OR 97339

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 complete with OHA it will be forwarded to IHN-CCO.

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 IHN-CCO.
- Care you were not sure about, but got anyway.
- Bills for services you did not agree to pay.
- Disputes on IHN-CCO 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 five business days from the day we got your complaint.

If we need more time, we will send you a letter within five 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 **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 **211info.org** website for help.

How to file a grievance

If you are unhappy with us, your health care services or your provider, you can file a grievance. We can help you write down your grievance or you can call it in. You can get help from your doctor or an authorized representative to file a grievance. You must give them written permission to file for you. We will try to make things better.

To file a grievance, contact us:
By mail: Appeals and grievances
PO Box 1310, Corvallis, OR 97339
In person: 2300 NW Walnut Blvd., Corvallis, OR 97330
Phone: **541-768-4550** (TTY **800-735-2900**)
Fax: 541-768-9765
Email: **SHPOGrvcTeam@samhealth.org**

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 five business days from the day we got your complaint.

If we need more time, we will send you a letter within five 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. You, your doctor, or your authorized representative can also file a grievance directly with OHA. To do this please contact OHA client services at **800-273-0557**.

If you are unhappy with how IHN-CCO handled your grievance, you can also share that with the Oregon Health Authority's client services unit at **800-273-0557** or an Oregon Health Authority Ombudsperson at **877-642-0450**.

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

IHN-CCO, 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. 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 about a service.

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. To support your appeal, you have the right to:

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

You must do these things within the appeal timeframes listed below.

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 **541-768-4550** (TTY **800-735-2900**). 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 PO Box 1310, Corvallis, OR 97339**.** You can also fax the form or written request to **541-768-9765**. **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 one 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 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 IHN-CCO 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 **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 during the appeal and hearings process.

You need to:

- Ask for this within 10 days of the date of notice or by the date this decision is effective, whichever is later.

You can call us at **541-768-4550** (TTY **800-735-2900**).

- 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**.
- **Answer "yes" to the question about continuing services on box 8 on page 4 on the Request to Review a Health Care Decision form.**

You can mail the form to: **Appeals and grievances PO Box 1310, Corvallis, OR 97339**

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 IHN-CCO and Medicare, you may have more appeal rights than those listed above. Call Customer Service at **541-768-4550** (TTY **800-735-2900**) for more information. You can also call Medicare at **800-MEDICARE (800-633-4227)**, 24 hours a day, seven days a week. TTY users should call **877-486-2048** 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 IHN-CCO at **541-768-4550** (TTY **800-735-2900**) 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 Management — 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.

Coinsurance — 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 health care 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 health care 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 **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.

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.

Prior approval (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 checkup 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 health care 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.

InterCommunity Health Network CCO

2300 NW Walnut Blvd., Corvallis, OR 97330
541-768-4550 | 800-832-4580 (TTY 800-735-2900)

Visit us online at **IHNtogether.org**