

Oregon Health Plan Client Handbook



October 2004

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Cambodian

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Lao

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Hmong

Se gorngv meih qiex zuqc longc naaiv buonv sou fiev dieh nyungc nzangc, fiev hlo nyei, Hluo nyei nzangc, siou waac hlaang, fai dieh nyungc, heuc 1-800-359-9517 fai TTY 1-800-621-5260

Mien

만일 다른 언어나 큰 활자, 점자, 녹음 테이프, 또는 다른 형식으로 된 이 안내서를 원하는 경우에는 전화 1-800-359-9517 또는 TTY 1-800-621-5260 번으로 연락하시기 바랍니다.

Korean

Accessible Services

Communicating with Us

Do you have a disability that makes it hard for you to read printed material? Do you speak a language other than English? We can give you information in one of several ways:

- Large print
- Audio tape
- Braille
- Computer disk
- Oral presentation (face-to-face or on the phone)
- Sign language interpreter
- Translations in other languages

Let us know what you need. Tell your worker or, if you have no case worker, call 503-373-0333 x 393 or TTY 503-373-7800.

Is Access a Problem?

Do barriers in buildings or transportation make it hard for you to attend meetings? To get state services?

- We can move our services to a more accessible place.
- We can provide the type of transportation that works for you.

You Have a Right to Complain

You can complain if:

- You keep getting DHS printed forms and notices, but you need them some other way.
- Our programs aren't accessible.

You have 60 days to make your complaint. Send your complaint to:

The Governor's Advocacy Office
500 Summer St NE, E17
Salem, OR 97301

1-800-442-5238
1-800-945-6214 TTY
503-378-6532 Fax

-or-

US Dept of Health & Human Services
Office for Civil Rights
2201 Sixth Avenue, Mail Stop RX-11
Seattle, WA 98121

1-800-362-1710
1-206-615-2296 TTY
1-206-615-2297 Fax
OCRComplaint@hhs.gov

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Welcome to the Oregon Health Plan

The Oregon Health Plan (OHP) is a state program that provides health care coverage to eligible clients.

This booklet was written to help you understand:

- The different ways people receive care under OHP managed care and fee-for-service.
- How to read your Office of Medical Assistance Programs (OMAP) Medical Care Identification.
- Health care coverage under OHP.
- The benefit packages under OHP.
- How to use the health services that are covered under OHP.
- What you need to know about managed care under OHP.
- Your rights and responsibilities as an OHP client.
- Your managed care rights and responsibilities, if you are enrolled in a Managed Care Plan.

Keep this booklet to answer questions about your health care coverage.

What Is the Oregon Health Plan?

Medicaid is a medical assistance program for low-income families. Both federal and state funds pay for the Medicaid program in states that choose to offer it. The federal government requires states that offer Medicaid to cover a set list of services for certain people, such as children. A state may decide, with federal input, what other services they can afford to offer and who else is eligible.

In Oregon, the Medicaid program is called the Oregon Health Plan (OHP). Under OHP:

- Eligibility has been expanded so more people can receive medical assistance.
- Health care services are provided depending on where they rank on the Prioritized List of Health Services.

At this time, approximately 50,000 people are receiving medical assistance through the Oregon Health Plan who would not be eligible under a regular Medicaid program.

Prioritized List of Health Services

Oregon Health Plan clients receive benefits based on where health care conditions and treatments are placed on a Prioritized List of Health Services. The list was developed by the Oregon Health Services Commission (HSC). The Commission is made up of doctors, nurses, and others concerned about health care issues. They are appointed by the Governor.

To create the first Prioritized List of Health Services, the Commission held many public meetings throughout the state to find out what health issues were important to Oregonians. The Commission then used that information to rank all health care procedures in order of importance. The HSC meets regularly to update the list. The Legislature does not have enough money to pay for everything on the list, so they use the money that is available to pay for the most important services. All Managed Care Plans and health care providers use this list to decide if they can provide a service under OHP. You will only be treated for a condition not on the currently funded part of the list if it is directly related to another condition whose treatment is funded. Your doctor will know if this applies to you. See pages 24-25 to learn more about services that are not covered by OHP.



OHP Terms and Definitions

Benefit Package: The medical, dental, or mental health services covered by OHP.

Branch Office: The Department of Human Services (DHS) office where your case record and worker are located.

Client: Anyone receiving Oregon Health Plan benefits.

Copayment: That part of a health care bill that a client must pay to a provider or a facility.

Dental Plan: Provides and coordinates dental services for its members.

Department of Human Services (DHS): Oregon's statewide health and human services agency. The Office of Medical Assistance Programs (OMAP) is part of the Health Services section of DHS.

Emergency Care: Services for a serious injury or sudden illness, including severe pain, that you believe might cause death or serious bodily harm if left untreated.

Fee-for-Service: Direct payment from OMAP to health care providers based on the services given.

Inpatient Hospital Care: Medical services provided to a person staying overnight in a hospital.

Managed Care: Services and treatments provided and coordinated by a Managed Care Plan or by a Primary Care Manager.

Managed Care Plan: The organization(s) with whom you are enrolled to coordinate your medical, dental and mental health care.

Medicaid: A state and federal program that pays for health care for low-income people.

Medical Plan: Provides and coordinates medical services for its members.

Member: An OHP client enrolled with a Managed Care Plan.

Mental Health Plan: Provides and coordinates mental health services for its members.

Mental Health Services: Services or treatments for mental or emotional disorders.

OHP Plus: A comprehensive benefit package of services that certain clients are eligible for. Most clients who meet traditional Medicaid eligibility requirements receive OHP Plus benefits.

OHP Standard: The OHP Standard package offers fewer services than OHP Plus. It is for clients who do not meet traditional Medicaid requirements. Most OHP Standard clients pay premiums. The Department offers OHP Standard benefit coverage when state funding allows.

OMAP Medical Care Identification (ID): A letter-sized sheet of paper, mailed monthly, that shows who in your household is covered by OHP and what benefit packages they receive. This is sometimes called a "medical card."

Office of Medical Assistance Programs (OMAP): The DHS office that runs the Medicaid part of OHP.

Oregon Health Plan (OHP): A state program of health assistance and care for low-income people.

Outpatient Hospital Care: Health care services or treatments given at a hospital or clinic without the person being admitted to the hospital.

Pharmacy Management Program: A program that requires clients who are not enrolled in a Medical Plan, or do not have other insurance, *to enroll with* one pharmacy for their prescription drugs.

Premium: A monthly payment some medical assistance clients must pay for OHP coverage.

Preventive Services: Services that help you stay healthy, such as well-child exams, immunizations (shots), educational programs, and breast x-rays.

Primary Care Manager (PCM): A doctor or other medical provider who provides and coordinates medical services when a Medical Plan is not available.

Primary Care Provider (PCP): A doctor or other provider you choose from your Medical Plan's list of providers to coordinate your medical *care*.

Prioritized List of Health Services: A listing of health care conditions and treatments ranked in order of effectiveness.

Provider: An individual, clinic, or other organization (doctor, dentist, hospital, pharmacy, etc.) that provides health services.

Referral: Approval from your Managed Care Plan or PCM to get services from another provider or specialist.

Service Area: The geographic area in which a Managed Care Plan provides services.

Specialist: A provider who deals with one area of health care, such as a heart doctor, obstetrician, or an oral surgeon.

Urgent Care: Services for a condition serious enough to be treated right away, but does not require emergency room care.

Well-Child Exam: A preventive service to be sure your child is healthy.

Worker: A staff person with the Department of Human Services who is assigned to help you with questions.

Service Delivery

There are two ways to receive health care through the Oregon Health Plan (OHP). They are fee-for-service and managed care.

Be sure to look at the "Dates of Coverage" ⑬ and "Managed Care/TPR" ⑧ columns of your OMAP Medical Care ID to see if you are enrolled in a Managed Care Plan.

Depending on where you live and other factors, you may be enrolled in a Managed Care Plan for some kinds of health care and receive health care from any provider who will take your OMAP Medical Care ID for others. For instance, you may be in a Medical Plan and a Mental Health Plan, but not a Dental Plan.

Some clients receive health care from fee-for-service providers for the first part of a month and then are enrolled in a Managed Care Plan for the remainder of the month. Check the "Dates of Coverage" and "Managed Care/TPR" columns of your ID every month to make sure nothing has changed.

If you have questions, call your worker. Your worker's phone number is located in column ⑥ on your OMAP Medical Care ID.

Fee-For-Service

Fee-for-service means that you are not enrolled in a Managed Care Plan. If you are not enrolled in managed care, you can receive health care from any provider who will take your OMAP Medical Care ID. That provider will bill OMAP directly for any services provided and will receive a "fee" for his or her "service."

If you are a fee-for-service client, the "Managed Care/TPR" column ⑧ on your OMAP Medical Care ID will not show an OHP Managed Care Plan. However, if you have private insurance, that insurance will be listed in this column.

Reasons why clients may not be enrolled in a Managed Care Plan include:

- There are no health care plans (medical, dental or mental health) available in the area they live in.
- Clients who are American Indian, Alaska Natives or are eligible for services through an Indian Health Services program are not required to enroll in an OHP managed care plan. These clients can choose to be in a managed care plan or receive health care from any provider who will take their OMAP Medical Care ID.
- New clients with the following conditions don't have to enroll in a managed care plan if they:
 - Are scheduled for surgery or are in the last three months of a pregnancy. These clients may have their enrollment in a managed care plan delayed until after surgery or the birth of the baby.
 - Have End Stage Renal Disease (ESRD) or receive routine dialysis treatment, or have received a kidney transplant within the last 36 months.

Remember!

If you are not enrolled in a Managed Care Plan, you can go to any health care provider who will take your OMAP Medical Care ID.

Pharmacy Management Program

If you are in the Pharmacy Management Program, you will be required to go to one pharmacy for your prescription drugs.



You will **not** be in the Pharmacy Management Program if you:

- Are enrolled in a Medical Plan.
- Have private major medical insurance.
- Are an American Indian, Alaska Native or eligible for benefits through an Indian Health Services program.
- Are a child in the care and custody of DHS.
- Are an inpatient or resident in a hospital, nursing facility, or other medical institution, or receiving services under the Home and Community Based or Developmental Disability waivers.

How the Program Works

When your first prescription is filled, you will be enrolled with the pharmacy that fills the prescription. OMAP will send you a new Medical ID showing the enrolled pharmacy in the managed care section of the ID.

You will have 30 days to call OMAP and change pharmacies if you do not want to be enrolled in the pharmacy listed on the Medical ID.*

Exceptions Allowed

You may receive drugs from a different pharmacy if:

- You have an urgent need to fill a prescription and your enrolled pharmacy is not available (for example, it is closed or you are out of the area).
- Your pharmacy does not have the prescribed drug in stock.

OHP Pharmacy Home-Delivery Program

Even though you may be enrolled with a pharmacy, you may also order prescription drugs through the OHP Pharmacy Home-Delivery Program. See page 35 for more information about this convenient service.

You May Change Pharmacy Enrollment:

- If you move.
- When you reapply for the OHP.
- If you are denied services by your enrolled pharmacy.

* To change pharmacies, call the OMAP Client Advisory Services Unit (CASU) at 1-800-273-0557 or TTY at 1-800-375-2863.

Managed Care

In managed care, one Managed Care Plan or Primary Care Manager (PCM) coordinates all of your health care needs.

If you are in managed care, you may be enrolled in any or all of the following:

- Medical Plan or PCM
- Dental Plan
- Mental Health Plan
- Chemical Dependency Plan (available in Deschutes County only)

What Are the Benefits of Managed Care?

- You and your family will have guaranteed access to health care.
- You will have access to health care 24 hours a day, 7 days a week.

Interpreter Services

If you are in managed care and need an interpreter for doctors visits or to assist you with questions, contact your plan. Interpreters can be available either by telephone or in person.



The information on pages 9-13 applies only to clients enrolled in a Managed Care Plan or PCM

The Managed Care Plans or Primary Care Manager (PCM) you are enrolled with are listed in column (8a) of your OMAP Medical Care ID.

If you receive non-emergency or non-urgent care services from providers who are not part of your plan, you may be billed for charges, including Medicare deductibles and coinsurances.

Changing Your Managed Care Plan or Primary Care Manager

You may change your Managed Care Plan or PCM:

- When you reapply for OHP coverage.
- If you move out of your Managed Care Plan service area, or away from your PCM.
- For any important reason that OMAP approves.

To change your Managed Care Plan or PCM, call your worker.

Medical Plans

When you enroll in a Medical Plan, your Medical Plan will ask you to choose a Primary Care Provider (PCP). Each family member may choose a different PCP.

Your Medical Plan will give you 30 days to choose a PCP. After 30 days your Medical Plan may choose a PCP for you.

Your medical services and treatments will be provided or coordinated by your PCP.

To Coordinate Your Medical Care, Your PCP Will:

- Keep your medical records in one place to give you better service.
- Provide access for you to medical care 24 hours a day, 7 days a week.
- Be your first contact when you need medical care, unless it's an emergency (see pages 31-32).
- Arrange for your specialty or hospital care when needed.



The information on pages 9-13 applies only to clients enrolled in a Managed Care Plan or PCM

Remember!

- Use your PCP for your medical care, except for emergency care (see pages 31-32).
- Use your Medical Plan's pharmacies.
- You must have a referral from your PCP before you see a specialist. If you do not have a referral, your plan may not pay for the care you receive. You may have to pay the specialist's bill.

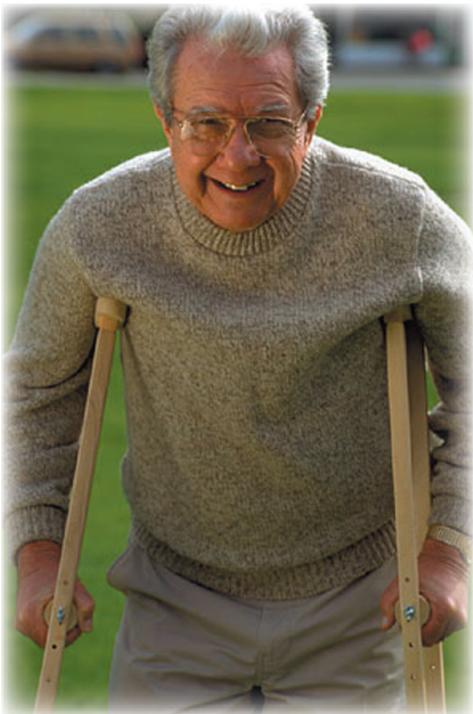
You can change your PCP:

- Within the first 30 days of enrollment in your Medical Plan.
- When you reapply for OHP coverage.
- For any important reason approved by your Medical Plan.

Call your Medical Plan to ask about changing your PCP.

Ask your Medical Plan when the change will go into effect. If you need medical care before the change goes into effect, call your Medical Plan. Your Medical Plan can help you get the care you need.

Exceptional Needs Care Coordinator (ENCC)



Each Medical Plan has an ENCC to assist members who have complex medical and/or special needs. ENCCs help coordinate health care services for members age 65 or older and members with disabilities. Members who have special medical supply or equipment needs, or who will require support services in obtaining care, may request help from an ENCC by calling their Medical Plan.

Primary Care Manager

Medical Plans are not available in all areas of the state, or to all clients. In order to make sure OHP clients can still receive the advantages of managed care, OMAP also contracts with individual providers to coordinate and manage your health care. These providers are called Primary Care Managers (PCMs).

If you are enrolled with a PCM, your medical services and treatments will be provided and coordinated by your PCM.



Each family member may choose a different PCM.

To Coordinate Your Medical Care, Your PCM Will:

- Keep your medical records in one place to give you better service.
- Provide access for you to medical care 24 hours a day, 7 days a week.
- Be your first contact when you need medical care.
- Arrange for your specialty or hospital care when needed.

If you are enrolled with a PCM, you will see the name and phone number of your PCM on your OMAP Medical Care ID in Column(8a).

Remember!

- Use your PCM for your medical care, except for emergencies (see pages 31-32).
- You must have a referral from your PCM before you see a specialist. If you do not have a referral, OHP may not pay for the care you receive. You may have to pay the specialist's bill.

Dental Plans

If you are enrolled in a Dental Plan, your Dental Plan will ask you to choose a dentist from their list of providers. Each family member may choose a different dentist. Your dental services and treatments will be provided or coordinated by your dentist through your Dental Plan.

To Coordinate Your Dental Care, Your Dentist Will:

- Keep your dental records in one place to give you better service.
- Provide access for you to dental care 24 hours a day, 7 days a week.
- Be your first contact when you need dental care, except in an emergency (see page 33).
- Arrange for your specialty dental care when needed.



Remember!

- Use your dentist for your dental care.
- If you are enrolled in a Medical Plan, use your Medical Plan's pharmacies.
- You must have a referral from your dentist before you see a dental specialist. If you do not have a referral, OHP may not pay for the care you receive. You may have to pay the specialist's bill.

For information on emergency dental services, see page 33.

Mental Health Plans

If you are enrolled in a Mental Health Plan, your mental health services and treatments will be provided or coordinated through your Mental Health Plan.

Mental health services include an assessment, management, therapy, medication management and inpatient psychiatric care from the appropriate Mental Health Plan.

To Coordinate Your Mental Health Care, Your Mental Health Plan Will:

- Keep your records in one place to give you better service.
- Provide access for you to mental health care 24 hours a day, 7 days a week.
- Be your first contact when you need mental health care.
- Arrange for your speciality or psychiatric hospital care when needed.

Remember!

- If you have a mental health crisis, call your Mental Health Plan.
- You must have a referral from your Mental Health Plan before you see a mental health specialist. If you do not have a referral, OHP may not pay for the care you receive. You may have to pay the specialist's bill.
- If you are enrolled in a Medical Plan, use your Medical Plan's pharmacies.

The following information applies to all clients

The word “provider” is used throughout this booklet to refer to:

- A PCM or PCP (for clients in managed care).
- A health care provider (for fee-for-service clients).

Benefit Packages

Benefit packages show the medical, dental or mental health services OHP covers for each client. Each client receives a benefit package based on certain things, such as age or condition. Members of your household may receive different benefit packages. An explanation of each benefit package is shown in this section. The current benefit packages include the following:

- OHP Plus
- OHP Standard
- Qualified Medicare Beneficiary (QMB)
- Citizen Waived-Alien Emergency Medical Assistance (CAWEM)

OHP Plus Benefit Package

OHP Plus is a comprehensive package of services that focuses on preventive care.

OHP Plus Eligibility

You receive the OHP Plus benefit package if you are financially eligible and you are:

- Pregnant.
- Under the age of 19.
- Receiving SSI.
- Receiving Temporary Assistance to Needy Families (TANF).
- Age 65 or older, blind, or disabled with income at or below the SSI standard.
- Age 65 or older, blind or disabled receiving state-paid long-term care services.

OHP Plus Coverage

OHP Plus covers medical, dental, mental health and chemical dependency services. Read more about covered services on pages 24 through 33. See also the Quick Reference chart on Page 17.



OHP Plus Copayments

Some OHP clients are required to make copayments for outpatient services and prescription drugs.

Amounts of OHP Plus Copayments Are:

- \$2 for generic prescription drugs (for each filled prescription).
- \$3 for brand name prescription drugs (for each filled prescription).
- \$3 for outpatient services (such as office visits to see a doctor, dentist or other health care provider). The copayment is only for the visit to the provider. You will not have copayments for treatments such as shots, lab tests or x-rays.

Clients Enrolled in Managed Care Plans

Managed Care Plans will not charge their members a copayment for services or prescription drugs that the plan pays for. Drugs for mental illness are not covered by Managed Care Plans and require copayments.

You will not pay a copayment for:

- Family planning services and supplies, such as birth control pills.
- Prescription drugs ordered through the OHP Home-Delivery Pharmacy Program. See page 35 for more information about this program.
- Emergency services.

If You Cannot Pay

If you cannot make a required copayment, you may still receive the drug product or health care service; however, you will still owe a debt to the pharmacy or health care provider for the copayment.

OHP Standard Benefit Package

OHP Standard is a reduced benefit package. It is similar to private insurance because clients with OHP Standard must pay monthly premiums to keep their coverage.

OHP Standard Eligibility

You may receive OHP Standard benefits if all the following are true:

- You are financially eligible
- You do not meet the requirements for OHP Plus or other benefit packages
- If the program is open for enrollment

NOTE: Effective July 1, 2004, the OHP Standard benefit package was closed to new applicants. Existing clients may keep your benefits as long as you remain

eligible, pay your premiums and renew your application in a timely manner. Ask your worker about eligibility requirements for OHP Standard benefits.

OHP Standard Coverage

OHP Standard benefits include the following:

- Physician services
- Lab and X-ray services
- Prescription drugs
- Limited emergency dental services
- Limited medical equipment and supplies:
 - Diabetic supplies (including blood glucose monitors)
 - Respiratory equipment (CPAP, BiPAP, etc.)
 - Oxygen equipment (such as concentrators and humidifiers)
 - Ventilators
 - Suction pumps
 - Tracheostomy supplies
 - Urology and ostomy supplies
- Outpatient chemical dependency services
- Outpatient mental health services
- Emergency transportation (by ambulance only)
- Limited hospital services
- Hospice care

The Quick Reference chart on Page 17 shows which services are available to clients with OHP Standard benefits. Services covered in the OHP Standard package are marked with an X in the Standard column. For more details about the services, see pages 24 through 33.

OHP Standard Copayments

Clients with the OHP Standard package are not required to pay copayments.

Your Benefit Package May Change

If you become pregnant, disabled, or meet other eligibility requirements for the OHP Plus benefit package, call your worker.

Quick Reference Coverage Chart

Covered Services	OHP Standard	OHP Plus
Acupuncture	Chemical Dependency only	X
Chemical dependency services	Outpatient only	X
Chiropractic and osteopathic manipulation		X
Dental	Limited emergency only	X
Emergency/urgent hospital services	X	X
Hearing aids & hearing aid exams		X
Home health		X
Hospice care	X	X
Hospital care	Limited	X
Immunizations	X	X
Laboratory services	X	X
Medical equipment and supplies	Limited*	X
Medical transportation	Emergency only	X
Mental health services	Outpatient only	X
Occupational therapy		X
Physical therapy		X
Physician services	X	X
Prescription drugs	X	X
Private duty nursing		X
Speech therapy		X
Vision care	Eye disease treatment only	X
X-rays	X	X

* Limited to only diabetic supplies, respiratory equipment, oxygen equipment, ventilators, suction pumps, tracheostomy supplies, urology and ostomy supplies.

OHP Standard Premiums

If you receive OHP Standard benefits, you must make a monthly payment for health care coverage. This monthly payment is called a premium. Clients who are American Indian, Alaska Native or are eligible for services through an Indian Health Services program are not required to make premium payments, even if they are on OHP Standard.

The amount of your premium is based on your gross income and family size. The premium amount stays the same until you reapply. Your premium requirement will begin the date your coverage begins.

If you are required to pay a premium, a bill will be mailed to you each month. You must pay your premiums every month, even if you didn't see your health care provider.

Premiums Must be Paid in Full and on Time

If premiums are **not** paid in full and on time:

- Clients in the home who are required to pay premiums will lose their health care coverage before the end of their six-month enrollment period.
- Clients who lose their health care coverage because they did not pay their premiums will not be considered for coverage again until:
 - At least six months have passed, and
 - Past-due premiums are paid, and
 - The program is open for new enrollment.
- Health care coverage will not change for any clients in the household who are not required to pay premiums.

Americans with Disabilities Act (ADA)

Clients with a disability may request an ADA accommodation in writing. If approved by DHS, the client may pay past due premiums at the time of re-enrollment. If the client's coverage has ended, it can be reopened upon payment of past premiums.

Qualified Medicare Beneficiary (QMB)

This program helps people who are eligible to receive hospital benefits through Medicare. QMB clients have limited income, but are not quite eligible for Medicaid coverage. The state helps by paying for QMB clients' Medicare premiums, deductibles and coinsurance.

Your Benefit Package May Change

If you become pregnant, disabled, or meet other eligibility requirements for the OHP Plus benefit package, call your worker.

Citizen Alien-Waived Emergency Medical Assistance (CAWEM)

These clients are not citizens of the United States and do not have an immigration status that meets Medicaid requirements. Their coverage is limited to emergency services, including delivery of newborns.

OMAP Medical Care ID

As an OHP client, you will be sent an OMAP Medical Care ID each month.

Check your OMAP Medical Care ID to make sure the information is correct. If it is not, call your worker.

Your OMAP Medical Care ID will show your branch office name, phone number, your worker's code, and the benefit package and copayment information for everyone on the ID (see pages 19-20).

Always carry your OMAP Medical Care ID. Show it every time you get health care services. If you do not show it, some providers may not see you or may make you pay for your visit.

It is illegal:

- To use your OMAP Medical ID for health services for anyone not listed on your ID.
- To copy or change your OMAP Medical Care ID.

If your name or address changes, let your worker know. The post office will not forward your OMAP Medical Care ID to your new address. You could lose your OHP benefits if your worker does not have your correct address.

Special Information for Managed Care Clients

You will also receive a Plan Identification card from your Medical and Dental Plans. These cards are very important because they identify you and have other important information for you and your provider. These cards tell you what to do in an emergency. You should present your Medical or Dental card whenever you need health care services. If you lose your Plan ID card, contact the Member Services Department of your Medical or Dental Plan.

1

2

7a

Copay Requirements

8a

Managed Care/TPR

A \$3 for outpatient services not paid for by your Plan (listed in 8a)

A

B \$2 Generic/\$3 Brand – for drugs not paid for by your Medical Plan (listed in 8a)

B

C

D

E

F

G

H

OMAP Medical Care Identification (ID)

4 Branch Name Division 5 Worker 6 Phone

9a Benefit Package

A – OHP Plus

C – Qualified Medicare Beneficiary (QMB)

D – Limited Medicaid

B – OHP Standard

E – CAWEM Emergency Medical

I

All non-emergency care must be approved by applicable Managed Care/TPR shown in field 8a. See OMAP General Rules OAR 410-120-1200 for specific benefit package limitations. All OMAP administrative rules can be found on the OMAP website at: www.dhs.state.or.us/healthplan/

10

Name of Eligible Person(s)

11

Recipient ID

12

Date of Birth

13

Dates of Coverage

7b

Copay Req

8b

ManagedCare/TPR

9b

Benefit Package

IMPORTANT:

■ This is your new OMAP Medical Care ID. Issued on:

■ Show this ID to all providers, even if you have a Managed Care Plan card.

■ Not valid outside the United States or US Territories.

14

Your OMAP Medical Care ID Shows:

- ① Your branch office's number.
- ② Your case number.
- ③ The address of your branch office.
- ④ The name of your branch office.
- ⑤ Your worker's code. Your worker can answer questions about your Medical ID and eligibility. Let your worker know if anything on your Medical ID is wrong.
- ⑥ Your worker's phone number.
- ⑦ a) Copayment requirements. (See page 33-34 for information about copayments)
b) Letters in this space refer to the copayment requirements (field ⑦a) for each family member. If this space shows "NO COPAYS," a copayment is not required for the time period listed in field ⑬.
- ⑧ a) Name and phone number of your Managed Care Plans, private insurance, or OMAP pharmacy.
b) Letters in this space refer to information listed in field ⑧a) and show where each family member must receive health care services. If this space is blank, the family member can get health care services during the time period listed in field ⑬ on a fee-for-service basis. This means you can see any health care provider who will take your Medical ID.
- ⑨ a) This section lists the possible benefit packages family members may be assigned to.
b) Letters in this field show which benefit package applies to each family member.
- ⑩ Name of each family member listed on the ID.
- ⑪ Every family member has a different recipient ID number. Health care providers use this for billing.
- ⑫ The birth date for each family member listed on the ID.
- ⑬ Dates show when each family member is:
 - Required to make a copayment (see field ⑦b).
 - Covered on a fee-for-service basis or by Managed Care Plans, a Primary Care Manager, private insurance, or an OMAP pharmacy (see field ⑧b).
- ⑭ Message box. Two messages are printed in this section every month.

Copayment Requirements

Copayment information in Field (7a) (Copayment Requirements) is preprinted on the ID. Letters in Field (7b) of the ID show which copayments in field (7a) apply for each family member. Not everyone in your family may need to make copayments. If a client does not need to make copayments, the words "NO COPAYS" will be printed in Field (7b).

Managed Care/TPR

Managed Care and Insurance Plans are listed in Field (8a) (Managed Care/TPR). The letters in Field (8b) show which plans and insurance information apply to each family member. If you are not enrolled in a managed care plan, this field will be blank.

Benefit Packages

All benefit packages are preprinted on the ID in Field (9a) (Benefit Package). The letter in Field (9b) shows which benefit package each family member has been assigned to. Some clients may have more than one benefit package. The ID does not list what is covered in your benefit package (see page 16 for this information).

Sample ID

The sample on page 22 gives us the following information about John Doe:

- Field (7b) after John's name spells out "NO COPAYS," so John knows he will not have to make copayments.
- John's ID shows an "A" in Field (8b). Box "A" in Field (8a) at the top of the page names the Medical Plan that John is enrolled in. Because there are no other letters in Field (8b), John knows that he is not enrolled in any other managed care plans.
- Field (9b), Benefit Packages, shows a "B." Field (9a) explains that "B" means OHP Standard.

The sample on page 22 gives us the following information about Janie Doe, who was born in 1994:

- Janie has "AB" copayments in (7b). Field (7a) at the top of the page tells her how much she will pay for outpatient services and prescription drugs.
- Field (8b) has the letters "BCDE" in it. This shows that Janie is enrolled in an OMAP Dental Plan ((8a) "B"), and OMAP Mental Health Plan ((8a) "C"), as well as having private medical insurance ((8a) "D") and private vision insurance ((8a) "E").
- The "A" in Field (9b) shows that Janie receives OHP Plus benefits.

Health Services

The health care services you may receive are based on the benefit package you have been assigned to. See pages 15-18 for specific information on the coverage provided under each benefit package.

Preventing health problems before they happen is a very important part of your care. Under OHP, you can get preventive services to help you stay healthy. Preventive services include check-ups and any tests to find out what is wrong. Be sure to discuss the recommended schedule for check-ups with your provider. Other preventive services include the following:



- Well-child exams
- Immunizations (shots) for children and adults (**not** for foreign travel or employment purposes)
- Routine physicals
- Pap smears
- Mammograms (breast x-rays) for women
- Prostate screenings for men
- Dental check-ups, exams and preventive dental care for children and adults
- Maternity and newborn care
- Maternity management (special services to help you have a safe pregnancy)

Some services have limits. Your provider can help answer your questions.

There are some services that are not covered even if treatment may be important. If you get a health care service that is not covered, you may have to pay the bill.

If you are in managed care, you will need to get a referral from your provider to see a specialist.

Not Covered Services

The following services are not covered:

- Treatment for conditions that get better on their own, such as colds
- Treatment for conditions for which home treatment works, such as sprains
- Cosmetic surgeries or treatments
- Treatments that are not generally effective
- Services to help you get pregnant

- Weight loss programs
- Buy-ups*

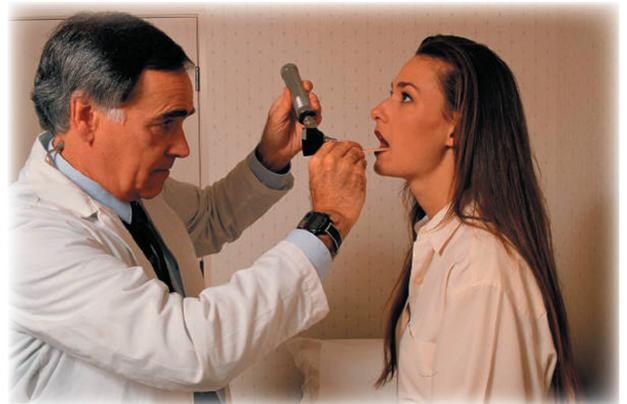
* To "buy up" means you get an item that is not covered by OHP by paying the difference between the item OHP covers and a more expensive, non-covered model. For example, OHP may cover a basic pair of eyeglasses but the client may want a more expensive pair that is not covered by OHP. The client tries to buy up by paying the difference between the two. This is not allowed.

Medical Services

The health care services you may receive are based on the benefit package you have been assigned to. See pages 15-18 for specific information on the coverage provided under each benefit package.

Medical Services Include the Following:

- Preventive services (check-ups, well-child exams)
- An exam or test (laboratory or x-ray) to find out what is wrong, whether the treatment for the condition is covered or not
- Treatment for most major diseases
- Hospital stays, x-ray, and lab services
- Substance abuse (alcohol and drug) treatment
- Vision care, routine screenings, and glasses
- Hearing services, hearing aids and batteries
- Hospice and home health care
- Some transplants
- Most prescription drugs
- Family planning
- 24-hour emergency care
- Specialist care and referrals
- Stop-smoking programs
- Diabetic supplies and education
- Physical, occupational and speech therapy
- Medical equipment and supplies
- Emergency ambulance

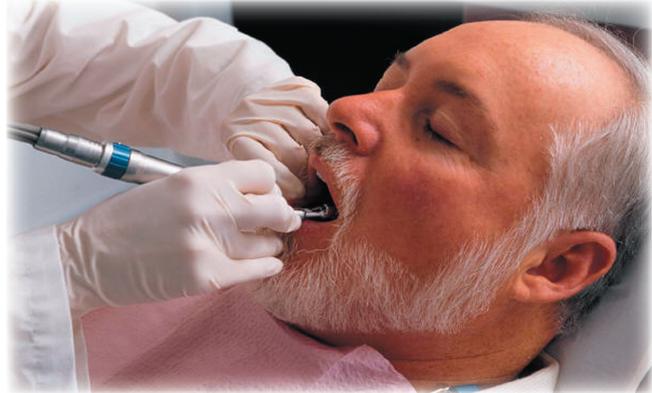


Dental Services

The health care services you may receive are based on the benefit package you have been assigned to. See pages 15-18 for specific information on the coverage provided under each benefit package.

Dental Services Include the Following:

- Preventive services (cleanings, fluoride treatments, sealants for children)
- Routine services (fillings, x-rays)
- Dental check-ups
- Tooth removal
- Dentures
- 24-hour emergency care
- Specialist care and referrals



Mental Health Services

The health care services you may receive are based on the benefit package you have been assigned to. See pages 15-18 for specific information on the coverage provided under each benefit package.

Mental Health Services Include the Following:

- Evaluations
- Therapy
- Consultations
- Case management
- Medication management
- Hospitalization
- Emergency services
- Programs to help with daily and community living

Pregnancy Care Coverage

Pregnancy care is covered under the OHP. If you become pregnant, call your worker right away. Your worker will make sure you do not lose medical coverage before your baby is born.

Pregnant clients:

- Receive services under OHP Plus.
- Are not charged premiums or copayments.

If you are pregnant, or think you might be, it is important that you see a health care provider right away.

Remember!

- Regular check-ups are important to have a healthy baby. Keep your appointments and follow your provider's advice.
- Alcohol and drugs taken before or during pregnancy can harm your unborn baby. If you need help for alcohol and drug use, talk to your provider.
- Now is a good time to stop smoking cigarettes. Smoking during pregnancy can harm your baby. Talk to your provider, to find out ways he or she can help you quit.
- If you need a specialist for your pregnancy care, your provider can refer you to one.
- Your provider can give you vitamins that will help keep your baby healthy during your pregnancy and help prevent birth defects.



Important Managed Care Information

If at all possible, try to stay within your Medical Plan's service area during the last 30 days of your pregnancy. However, if you must leave your Medical Plan's service area, your Medical Plan is only responsible for emergency care outside the Plan's service area. The Plan will cover the delivery and the baby's newborn check-up in the hospital, but not the prenatal care. The Plan will also pay for any other emergency care involving your baby.

Newborn Care Coverage

Call your worker as soon as your baby is born. Your baby has medical coverage until his or her first birthday, even if you are no longer eligible for the OHP.

When you call your worker, give the following information about your baby, and your baby's parents:

- Date of birth
- Name
- Sex
- Social Security number (as soon as your baby gets one)



Important Managed Care Information

If you are in a Managed Care Plan, your newborn child will be covered by your Medical Plan at the time of birth. However, you will still need to call your worker to enroll your baby in your plan as soon as possible (preferably within 2 weeks).

Chemical Dependency Treatment

The health care services you may receive are based on the benefit package you have been assigned to. See pages 14-18 for specific information on the coverage provided under each benefit package.

Problems with alcohol or other drugs affect the whole family. You may need treatment if drinking alcohol or using other drugs causes problems in your life:

- Fighting with your loved ones
- Missing work
- Getting sick
- Having trouble with the law

Identifying problems before they become worse will increase your chance of recovery. You do not need a referral to receive help for problems with alcohol or drugs. You can go to:

- Any provider who will take your OMAP Medical Care ID.
- Your Primary Care Provider or Primary Care Manager.

Outpatient Treatment and Methadone Services

OHP covers outpatient treatment and methadone services. Outpatient treatment means you can stay at home with your family and keep working while getting treatment.

Residential Services

Residential services include treatments provided in a 24-hour care facility.

OHP does not cover residential services; however, if needed, you may get residential services from other programs.

For more information on residential services, call the Oregon Partnership Alcohol and Drug HelpLine at:

- 1-800-923-HELP (4357) 1-877-553-TEEN (8336)--youth line
- 1-877-515-7848 for Spanish speaking clients

Stop Smoking Programs

OHP pays for services to help you stop smoking. Talk to your provider for more information.



Oregon Quit Line: 1-877-270-STOP (7867)
TTY: 1-877-777-6534

Family Planning and Related Services

Family planning and related services are available to women, men and teens.

- Family planning includes the following services:
 - Family planning visits (physical exam and contraceptive education)
 - Contraceptive supplies such as oral contraceptives and condoms
 - Sterilization services (tubal ligations and vasectomies)
- "Related services" include the following:
 - Pap smear
 - Pregnancy test
 - Screenings for sexually transmitted diseases (STDs)
 - Abortions
 - Testing and counseling for AIDS and HIV

Even if you're in a Managed Care Plan, you can go to any of the following places to receive the services shown above :

- A county health department
- A family planning clinic
- Any provider who will take your OMAP Medical Care ID
- Your Primary Care Provider or Primary Care Manager.

Important Managed Care Information

You do not need a referral from your Primary Care Provider or Primary Care Manager to get the services listed above.

Transportation

You must find a way to get to your health care appointments. If transportation is a problem, you might:

- Take the bus.
- Ask a friend or relative to drive you.
- Find a volunteer from a community service agency.

If you cannot find a ride to your appointment, your worker may be able to help. Call your worker at least one week before your appointment.

If you cancel or change your appointment, call your worker right away to cancel or change your ride.

Emergency Medical Care



An emergency is a serious injury or sudden illness, including severe pain, that you believe might cause death or serious bodily harm if left untreated. If you are pregnant, emergency services also include your unborn baby's health.

If you believe you have an emergency, call 911 or go to the nearest emergency room. Emergency care is covered 24 hours a day, 7 days a week.

Emergency Care When You're Away from Home

If you are traveling and have an emergency, go to the nearest emergency room or call 911. Emergency services are only authorized for as long as the emergency exists. Call your Primary Care Provider to arrange for further care if it is needed while you are gone. Also, call for follow-up or transfer of your care.

Take Your Medical ID

At the emergency room, show both your OMAP Medical Care ID and your Medical Plan card (if you are in managed care). The emergency room staff will call your provider if they need to know more about you.

If It's Not Really an Emergency

If you use an ambulance or the emergency room for something that OMAP does not consider an emergency, you may have to pay the bill.

Emergency room care is very expensive. Do not go to the emergency room for care that should take place in your provider's office. Care for sore throats, colds, flu, back pain, and tension headaches is not considered an emergency.

If you are not sure if your condition is serious enough to go to an emergency room, call your provider and ask where to get treatment. Someone is available to give you advice 24 hours a day, 7 days a week. Speak to the provider on call, even if he or she is not your usual doctor or nurse practitioner.

Urgent Care

An urgent medical condition is serious enough to be treated right away, but does not require emergency room care.

For urgent care, call your provider. Your provider has phone coverage 24 hours a day, 7 days a week. They will give you advice on what to do.

If you cannot reach your provider, go to an Urgent Care Center.

If you have a mental health crisis, call your Mental Health Plan.

Follow-up to Emergency or Urgent Care

After you are released from the emergency room or from an urgent care clinic, call your Primary Care Provider as soon as possible. Tell your provider where you were treated and why. Your Primary Care Provider will handle all your follow-up care and schedule another appointment, if it is needed.

Dental Emergency and Urgent Care

The health care services you may receive are based on the benefit package you *receive*. See pages 15-18 for specific information on the coverage provided under each benefit package.

A dental emergency is dental care requiring **immediate** treatment. Examples of dental emergencies follow:

- Severe tooth pain
- A tooth knocked out
- Serious infection

Urgent dental care is dental care requiring **prompt** but not immediate treatment. Examples of urgent conditions follow:

- A toothache
- Swollen gums
- A lost filling

If you have a dental emergency or urgent care need, call your dentist or your Dental Plan (if you are in one).

Travel



Outside of Oregon

If you travel outside of Oregon, OHP only covers emergency services for you. You may be billed for services if the provider does not enroll as an OMAP provider.

After you receive emergency treatment, call your Primary Care Provider to arrange for further care if it is needed while you are gone. Also, call for follow-up or transfer of your care.

Travel Outside of the United States

If you travel outside the United States (including Canada and Mexico), OHP will not cover any health care services you get in another country.

Medicare

If you have Medicare coverage and you are in managed care, contact your Medical Plan to find out about your coverage while traveling.

Travel Outside of Your Managed Care Service Area

If you travel out of your managed care service area and need health services, call your Primary Care Provider or Primary Care Manager, unless it is an emergency situation (see pages 31-32).

Travel and Pregnancy

If at all possible, try to stay within your Medical Plan's service area during the last 30 days of your pregnancy. However, if you must leave your Medical Plan's service area, your Medical Plan is only responsible for emergency care outside the plan's service area. The plan will cover the delivery and the baby's newborn check-up in the hospital but not the prenatal care. The plan will also pay for any other emergency care involving you or your baby.

OHP Home-Delivery Pharmacy Services

This program lets **fee-for-service** clients order and receive medications in the mail at home or at your clinic. You can:

- Order ongoing prescriptions for the entire family.
- Order refills by mail or phone.
- Be guaranteed quality and safety.
- Have delivery within eight to ten days.
- Order up to a three-month supply at one time.

You do not have to make copayments on drugs provided through the OMAP Home-Delivery Pharmacy.

You can use these services even if you are restricted to one pharmacy through the Pharmacy Management Program.

Your doctor can send your prescription to the home-delivery service or you can enroll yourself by calling 1-877-935-5797 toll-free. Customer service representatives are available Monday through Friday from 8 a.m. to 5 p.m.

For more information, call your worker.



If You Get a Bill

If you pay a medical, dental, or mental health bill yourself, OMAP will **not** pay you back.

If you get a bill (other than for a copayment) from a provider, call one of the places below for help:

- The medical, dental, or mental health plan responsible for the bill
- OMAP Client Advisory Services Unit at 1-800-273-0557 (TTY 1-800-375-2863) if:
 - You are not in managed care.
 - You have a PCM.
 - Your health plan did not resolve the billing problem.

Remember!

- If you get a service that is not covered by OHP, you may have to pay the bill.
- Providers may bill you for unpaid copayments.

If You Have Questions or Problems

If you have a question or problem with your health care coverage or provider, there are ways to resolve it.

If you are in a Managed Care Plan, you can either:

- Call your Managed Care Plan at the number shown on your OMAP Medical Care Identification.
- Call the Client Advisory Services Unit at 1-800-273-0557 (TTY 1-800-375-2863), to discuss your problem.
- Fill out an OHP Complaint form (OHP 3001). You can get this form from the OMAP Client Advisory Services Unit or from your worker.

If you are not enrolled in managed care, you can either:

- Call the Client Advisory Services Unit to discuss your problem.
- Fill out an OHP Complaint form (OHP 3001). You can get this form from the OMAP Client Advisory Services Unit or from your worker.



Complaint and Hearing Processes

Your OHP providers want to give you the best health care possible. If anything does go wrong, you need to follow the steps below.

Clients in Managed Care

- **Complaints.** A complaint is dissatisfaction with any matter (such as staff rudeness or unresolved billing) other than an "action." You can contact your managed care plan's Member Services (customer service unit) by phone or in writing to file a complaint. They will address your complaint within 30 days.
- **Actions and appeals.** If you receive a Notice of Action (such as a denial of services), and you disagree with the decision, you must first request an appeal from your managed care plan. You can appeal either orally or in writing within 45 days of the date of the letter. If you call, you will have to follow up with a written, signed appeal. **You must complete the plan's appeal process before you can request a hearing from OMAP.**
- **Medicare appeal.** If you are in managed care and also have Medicare benefits, you may have additional appeal rights. Contact your plan's Member Services for further information.

Clients Not Enrolled in Managed Care

If you disagree with a decision made by OMAP, complete the Administrative Hearing Request form (DHS 443). Your worker can give you the form and help you complete it.

All Clients

- If you get services on an ongoing basis (such as physical therapy or home health care) and they are denied, you can ask to continue getting the services while you wait for your hearing. Ask your worker about this.
- You can request an expedited hearing if you feel you have a problem that poses an "immediate, serious threat to your life or health." OMAP will review your medical records to see if you qualify.
- Neither your plan nor OMAP can treat you badly because you have filed a complaint or requested a hearing. If you believe you have been mistreated, call your worker or the OMAP Client Advisory Services Unit.
- If you need an interpreter for a hearing, one will be provided for you.

Your Right to Make Health Care Decisions

If you are an adult, you have the right to know about any medical treatment your doctor recommends for you and to refuse it if you choose. However, a serious illness or sudden injury could leave you unable to make decisions or express your wishes. In such a situation, your relatives would have to decide what you would want.



Oregon has a law that allows you to say in writing, ahead of time, how you would want to be treated if you were seriously ill or injured. The legal documents used to do this are called Advance Directives. The Advance Directive lets you name a person to direct your health care when you cannot do so. This person is called your health care representative. Your health care representative does not need to be a lawyer or health care professional. It should be someone with whom you have discussed your wishes in detail. Your health care representative must agree in writing to represent you.

The Advance Directive allows you to give instructions for health care providers to follow if you become unable to direct your care. The Advance Directive lets you tell your doctor to stop life-sustaining help if you are near death. This tells your doctor that you do not want your life prolonged if you have an injury or illness or disease that two doctors agree you will not recover from. You will get care for pain and to make you comfortable no matter what choices you make.

The Advance Directive is only valid if you voluntarily sign it when you are of sound mind. Unless you limit the duration of the Advance Directive it will not expire. You also may revoke your Advance Directive at any time. You have the right to decide your own health care as long as you are able to, even if you have completed the Advance Directive. Completing the Advance Directive is your choice. If you choose not to fill out and sign the Advance Directive form, it will not affect your health plan coverage or your access to care.

The Oregon Advance Directive forms are available at no cost from your Medical Plan (if you are in managed care), or by contacting your local hospital. For more information about Advance Directives, call your Medical Plan (if you are in managed care) or Oregon Health Decisions in Portland at 503-241-0744 or 1-800-422-4805.

Healing Arts Professionals

The following is a list of identified healing arts professionals licensed in the State of Oregon.

Not all Managed Care Plans cover the services of all healing arts professionals.

You may need a referral from your PCP or PCM to see a healing arts professional. If you do not have a referral, you may have to pay the bill. No referral is needed for covered chemical dependency (alcohol and drug) treatment, family planning, or related services.

Acupuncturists	Optometrists
Audiologists	Osteopathic Physicians
Chiropractic Physicians	Pharmacists
Clinical Social Workers	Physical Therapists
Counselors, Professional	Physical Therapist Assistants
Dental Hygienists	Physicians, MD
Dental Specialists	Physician Assistants
Dentists, General	Podiatrists
Denturists	Psychiatric Social Workers*
Dieticians	Psychologists
Hearing Aid Dealers	Psychologist Associates
Marriage and Family Therapists	Radiologic Technologists (Full License)
Massage Technicians	Radiologic Technologists (Limited Permit)
Midwives, Licensed Direct Entry (LDEM)	Respiratory Therapists
Naturopathic Physicians	School Counselors
Nurses, Licensed Practical	School Psychologists
Nurse Practitioners	Speech Pathologists
Nurses, Registered	
Occupational Therapists	
Occupational Therapy Assistants	

* *Not all psychiatric social workers are licensed.*

OHP Client Rights

- To be treated with dignity and respect
- To be treated by providers the same as other people seeking health care benefits to which you are entitled
- To obtain covered substance abuse treatment, family planning, or related services without a referral
- To be actively involved in the development of your treatment plan
- To receive information about your condition and covered and non-covered services, to allow an informed decision about proposed treatment(s)
- To consent to treatment or refuse services and be told the consequences of that decision, except for court-ordered services
- To receive covered services under the OHP which meet generally accepted standards of practice and are medically appropriate
- To obtain covered preventive services
- To have access to urgent and emergency services 24 hours a day, 7 days a week
- To receive a referral to specialty providers for medically appropriate, covered services
- To have a clinical record maintained which documents conditions, services received, and referrals made.
- To have a friend, family member, or advocate present during appointments and at other times as needed within clinical guidelines
- To have access to your own clinical record, unless restricted by statute
- To transfer a copy of your clinical record to another provider
- To make a statement of wishes for treatment (Advance Directive) and obtain a power of attorney for health care
- To receive written notice before a denial of, or change in, a service level or benefit is made, unless such notice is not required by federal or state regulations
- To know how to make a complaint with the OMAP Client Advisory Services Unit and receive a response from that Unit
- To request an Administrative Hearing with the Department of Human Services
- To receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency
- To receive necessary and reasonable services to diagnose the presenting condition
- To receive a notice of an appointment cancellation in a timely manner

OHP Client Responsibilities

- To be on time for appointments made with providers and call in advance if you are going to be late; or to cancel, if you are unable to keep the appointment
- To show your OMAP Medical Care ID at every appointment. If you do not show it, some providers may not see you or may make you pay for your visit
- To ask your provider if a service is covered under the OHP, before you get the service
- To seek periodic health exams, check-ups, and preventive services from your medical, dental or mental health providers
- To use urgent and emergency care appropriately
- To give accurate information for the clinical record
- To help the provider or clinic obtain clinical records from other providers. This may include signing a release of information form
- To ask questions about conditions, treatments and other issues related to your care that you don't understand
- To help in the creation of a treatment plan with the provider
- To follow prescribed, agreed-upon treatment plans
- To tell the DHS worker of a change of address or phone number
- To tell the DHS worker if someone in the family becomes pregnant
- To tell the DHS worker of the birth of a child
- To treat all providers and personnel with respect
- To tell the DHS worker if there is any other insurance available
- To pay for non-covered services you receive
- To pay the monthly OHP premium on time, if required
- To pay required copayments
- To sign a release so that DHS and your Plan can get information that is pertinent and needed to respond to an Administrative Hearing request in an effective and efficient manner

Managed Care Member Rights

In addition to those rights shown on page 40, managed care clients have the right to:

- Select or change your Primary Care Provider (PCP).
- Have the Plan's written materials explained in a manner that is understandable.
- Know how to make a complaint with the Plan and receive a response from the Plan.

Managed Care Member Responsibilities

In addition to those responsibilities listed on Page 41, as a member of a Managed Care Plan, you have the responsibility to:

- Choose your provider or clinic, once enrolled.
- Obtain services only from your PCP (except in an emergency) or through plan providers upon referral from your PCP.
- Obtain a referral to a specialist from your PCP or clinic before seeking care from a specialist unless self referral to the specialist is allowed.
- Notify the plan or PCP within 72 hours of an emergency.
- Assist the plan in pursuing any third-party resources available and to pay the plan the amount of benefits it paid for an injury from any recovery received from the injury.
- Bring issues or complaints to the attention of the plan.

Client Access to Clinical Records

An OHP client may have access to his or her own clinical records. A client may also ask to have his or her medical records corrected.

For clients in managed care, plans and their providers must provide copies within ten working days of the request from the member. Plans and their providers may charge the OMAP member reasonable copying costs.



Certificate of Creditable Coverage (after you leave OHP)

Many private health insurance companies temporarily deny or reduce benefits for prior (pre-existing) medical conditions. However, they can't do this if you had health insurance coverage:

- For at least 18 months in the past two years.
- With no breaks longer than 63 days.

The new insurance company may require a Certificate of Creditable Coverage as proof of previous insurance.

If you need a certificate to verify your OHP coverage, contact the Client Advisory Services Unit at 1-800-273-0557. Upon your request, that unit will mail or fax the certificate to you or to your new insurance company.

Who to Call

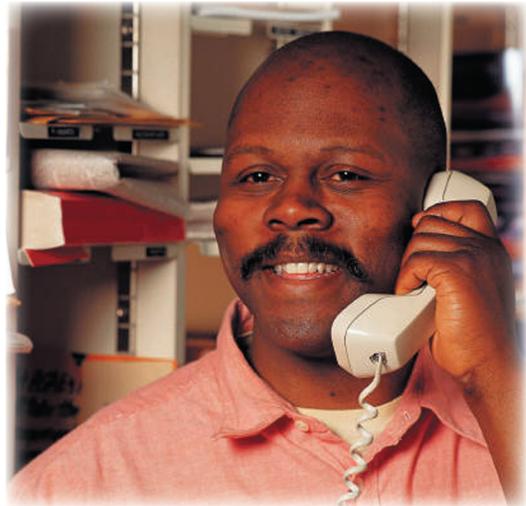
Below is a list of different offices that may be able to answer questions you may have. Please read carefully what each office can help you with.

These phone lines are very busy, so you may have to re-dial several times before you get through.

When to Call Your Worker

Call your worker if you:

- Get pregnant.
- Have a baby.
- Move.
- Have questions about your eligibility.
- Get or lose other health insurance.
- Want to change your Managed Care Plans or PCM.
- Want to request a hearing.
- Have not received your OMAP Medical Care ID.
- Have family members move in or out of your home.
- Need this booklet in another language, large print, Braille, on tape, computer disk, or in an oral presentation.
- Become eligible for health insurance through an employer.
- Become disabled or determined eligible for SSI.
- Do not have transportation to or from a health care appointment.



Your worker's identification and telephone number are on your OMAP Medical Care ID in fields ⑤ and ⑥.

The OHP Central Branch Office is 1-800-699-9075 (TTY 503-373-7800).

OHP Client Advisory Services Unit (CASU)

500 Summer St NE, E35
Salem, Oregon 97301

1-800-273-0557

TTY 1-800-375-2863

FAX 503-945-6898

Like any insurance company, the Oregon Health Plan has a group of customer service representatives to help you understand and use your coverage. Call CASU if you need a client advisor to:

- Provide you general information about your medical and dental coverage.
- Coach you on how to resolve problems involving access or quality of care.
- Help you resolve what you consider to be an inappropriate denial of covered benefits.
- Explain the OHP managed care system and help you navigate through that system.
- Research and resolve medical billings from your health care providers or collection agencies.
- Send you another client handbook or other written materials you need.
- Take your request for changing an assigned pharmacy.
- Advise you about OHP premiums.
- Advise you about OHP copayments.
- Send you or your new health insurance company a Certificate of Creditable Coverage when you leave the OHP and need to provide proof of prior coverage.

Note: CASU advisors cannot send you a list of health care providers or refer you to any specific doctor.

OHP Premium Billing Office

P O Box 3949
Portland, OR 97208

503-282-3001

1-800-922-7592

TTY: 1-800-735-2900

Contact the OHP Premium Billing Office to:

- Make sure your premium payment was received.
- Find out your current premium balance.
- Find out where or how to send payments.
- Verify current premium amounts or due dates.

When to Call Your Managed Care Plan

If you're in managed care, call your Managed Care Plan:

- To change your PCP.
- To ask which providers are taking new patients.
- If you have a problem with your Managed Care Plan's services.
- If you get or lose other health insurance.
- If you need urgent care.
- If you get emergency care.
- To ask what services are covered and not covered.
- To find out which hospital, pharmacy, or vision provider to use.
- To get special help for a disability.

Domestic Violence

This is a list of some of the warning signs of an abusive relationship. You may be in an abusive relationship, if your current or past partner or spouse:

- Puts you down.
- Stops you from getting or keeping a job.
- Makes threats against you or your children.
- Makes you afraid for your safety.
- Keeps you from seeing your friends or family.
- Shoves, grabs, slaps, punches, pinches, strangles, kicks, hits or chokes you.
- Tries to hurt you in any other way.



Call one of these phone numbers for confidential help in creating a safety plan and to get support and information:

Portland Women's Crisis Hotline

1-888-235-5333
503-235-5333 (Portland)
503-419-4357 (TTY)

National Domestic Violence

1-800-799-SAFE (7233)
1-800-787-3224 (TTY)

Department of Human Services

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This letter is available in other languages and alternate formats that meet the guidelines for the Americans with Disabilities Act (ADA).

Contact DHS at: Phone 503-945-7021, TTY 503-947-5330 or FAX 503-373-7690.

The Department of Human Services (DHS) provides many types of services, such as health and social services. DHS staff must collect information about you to provide these services. DHS knows that information we collect about you and your health is private. Federal and state laws require DHS to protect this information. We call this information “protected health information (PHI).”

The Notice of Privacy Practices will tell you how DHS may use or disclose information about you. Not all situations will be described. DHS is required to give you a notice of our privacy practices for the information we collect and keep about you. DHS is required to follow the terms of the notice currently in effect.

DHS May Use and Disclose Information Without Your Authorization

For Treatment. DHS may use or disclose information with health care providers who are involved in your health care. For example, information may be shared to create and carry out a plan for your treatment.

For Payment. DHS may use or disclose information to get payment or to pay for the health care services you receive. For example, DHS may provide PHI to bill your health plan for health care provided to you.

For Health Care Operations. DHS may use or disclose information in order to manage its programs and activities. For example, DHS may use PHI to review the quality of services you receive.

Appointments and Other Health Information. DHS may send you reminders for medical care or checkups. DHS may send you information about health services that may be of interest to you.

For Public Health Activities. DHS is the public health agency that keeps and updates vital records, such as births and deaths, and tracks some diseases.

For Health Oversight Activities. DHS may use or disclose information to inspect or investigate health care providers.

As Required by Law and For Law Enforcement. DHS will use and disclose information when required or permitted by federal or state law or by a court order.

For Abuse Reports and Investigations. DHS is required by law to receive and investigate reports of abuse.

For Government Programs. DHS may use and disclose information for public benefits under other government programs. For example, DHS may disclose information for the determination of Supplemental Security Income (SSI) benefits.

To Avoid Harm. DHS may disclose PHI to law enforcement in order to avoid a serious threat to the health and safety of a person or the public.

For Research. DHS uses information for studies and to develop reports. These reports do not identify specific people.

Disclosures to Family, Friends, and Others. DHS may disclose information to your family or other persons who are involved in your medical care. You have the right to object to the sharing of this information.

Other Uses and Disclosures Require Your Written Authorization. For other situations, DHS will ask for your written authorization before using or disclosing information. You may cancel this authorization at any time in writing. DHS cannot take back any uses or disclosures already made with your authorization.

Other Laws Protect Protected Health Information (PHI). Many DHS programs have other laws for the use and disclosure of information about you. For example, you must give your written authorization for DHS to use and disclose your mental health and chemical dependency treatment records.

Your Protected Health Information (PHI) Privacy Rights

When information is maintained by DHS as a public health agency, the public health records are governed by other state and federal laws and are not subject to the rights described below.

Right to See and Get Copies of Your Records. In most cases, you have the right to look at or get copies of your records. You must make the request in writing. You may be charged a fee for the cost of copying your records.

Right to Request a Correction or Update of Your Records. You may ask DHS to change or add missing information to your records if you think there is a mistake. You must make the request in writing, and provide a reason for your request.

Right to Get a List of Disclosures. You have the right to ask DHS for a list of disclosures made after April 14, 2003. You must make the request in writing. This list will not include the times that information was disclosed for treatment, payment, or health care operations. The list will not include information provided directly to you or your family, or information that was sent with your authorization.

Right to Request Limits on Uses or Disclosures of PHI. You have the right to ask that DHS limit how your information is used or disclosed. You must make the request in writing and tell DHS what information you want to limit and to whom you want the limits to apply. DHS is not required to agree to the restriction. You can request that the restrictions be terminated in writing or verbally.

Right to Revoke Permission. If you are asked to sign an authorization to use or disclose information, you can cancel that authorization at any time. You must make the request in writing. This will not affect information that has already been shared.

Right to Choose How We Communicate with You. You have the right to ask that DHS share information with you in a certain way or in a certain place. For example, you may ask DHS to send information to your work address instead of your home address. You must make this request in writing. You do not have to explain the basis for your request.

Right to File a Complaint. You have the right to file a complaint if you do not agree with how DHS has used or disclosed information about you.

Right to Get a Paper Copy of This Notice. You have the right to ask for a paper copy of this notice at any time.

How to Contact DHS to Review, Correct, or Limit Your Protected Health Information (PHI)

You may contact your local DHS office or the DHS Privacy Officer at the address listed at the end of this notice to ask:

- To look at or copy your records.
- To correct or change your records.
- To limit how information about you is used or disclosed.
- For a list of the times DHS disclosed information about you.
- To cancel your authorization.

DHS may deny your request to look at, copy or change your records. If DHS denies your request, DHS will send you a letter that tells you why your request is being denied and how you can ask for a review of the denial. You will also receive information about how to file a complaint with DHS or with the U.S. Department of Health and Human Services, Office for Civil Rights.

How to File a Complaint or Report a Problem

You may contact any of the people listed below if you want to file a complaint or to report a problem with how DHS has used or disclosed information about you. Your benefits will not be affected by any complaints you make. DHS cannot retaliate against you for filing a complaint, cooperating in an investigation, or refusing to agree to something that you believe to be unlawful.

Oregon Department of Human Services

The Governor's Advocacy Office
500 Summer St NE, E17
Salem, OR 97301-1097

Phone: 1-800-442-5238
Fax: 503-378-6532 (Salem)
E-mail: GAO.info@state.or.us
TTY: 503-945-6214

Office for Civil Rights

Medical Privacy Complaint Division
US Dept. of Health & Human Services
2201 Sixth Avenue, Mail Stop RX-11
Seattle, WA 98121

Phone: 1-800-362-1710
TTY: 1-206-615-2296
Fax 1-206-615-2297
E-mail: ocrprivacy@hhs.gov

For More Information About Privacy

General questions about privacy issues at DHS can be sent to:

Oregon Department of Human Services
Privacy Officer
500 Summer St NE, E24
Salem, Oregon 97301-1097

E-mail: dhs.privacyhelp@state.or.us

Phone: 503-945-5780

Internet: www.dhs.state.or.us/admin/info_security/index.html



Important Names and Phone Numbers

for each family member:

Name _____ Recipient ID # _____

PCP or PCM _____ Phone _____

Name _____ Recipient ID # _____

PCP or PCM _____ Phone _____

Name _____ Recipient ID # _____

PCP or PCM _____ Phone _____

Name _____ Recipient ID # _____

PCP or PCM _____ Phone _____

Name _____ Recipient ID # _____

PCP or PCM _____ Phone _____

Name _____ Recipient ID # _____

PCP or PCM _____ Phone _____

Medical Plan _____ Phone _____

Dental Plan _____ Phone _____

Mental Health Plan _____ Phone _____

Worker Code _____ Phone _____



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