PacificSource Coordinated Care Organization (CCO)

Your Oregon Health Plan Coverage

Columbia Gorge

For members who live in Hood River and Wasco counties.

Updated 01/01/2024

PacificSource Community Solutions

MM4325_0823_OHAApproved 12142023

Handbook Updates

PacificSource Community Solutions 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: https://pacificsource.com/medicaid/your-plan/member-handbook. If you need help or have questions, call Customer Service at 800-431-4135 (TTY: 711). We accept all relay calls.

Getting Started:

You will be receiving a survey in the mail that will help PacificSource Community Solutions know how to support you with your physical, behavioral and oral health care needs. To learn more about this survey, go to page 31.

Complete and return your survey in any of these ways:

- Phone: 888-970-2507
- Fax: 541-385-3123
- Mail: PacificSource Community Solutions
  Health Assessment Processing Center
  PO Box 5703
  Hopkins, MN 55343
- Email: MedicaidMSS@pacificsource.com

Helpful Tips

Some questions have been answered or can be asked here https://www.oregon.gov/oha/hsd/ohp/pages/client-questions.aspx

Some PacificSource Community Solutions' members can get extra benefits like rides to appointments, flexible services, 24-hour NurseLine and help to quit smoking. Call PacificSource Community Solutions to find out more.

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

If you are looking for:

- Benefits. Go to page 35
- Primary Care Providers. Go to page 27
- Prior Approvals and Referrals. Go to page 36
- Rights and Responsibilities. Go to page 23
- Rides to Care. Go to page 83
- Care Coordination. Go to page 33
- Prescriptions. Go to page 89
- Emergency Care. Go to page 93
- How long it takes to get care. Go to page 74
- Grievances, Complaints and Appeals. Go to page 115

- Always carry your OHP and PacificSource Community Solutions' member ID cards with you.
    - Note: These will come separately, and you will receive your OHP ID card before your PacificSource Community Solutions' member ID card.

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

- Your Name
- Your ID number
- Your Plan Information
- Your Primary Care Provider Name and Information
- Customer Service Phone Number
- Language Access Phone Number

- My Primary Care Provider is _____
    - Their number is _____
- My Primary Care Dentist is_____
    - Their number is _____
- Other Providers I have are _____
    - Their number is _____
- My nonemergent medical transportation (free ride to care) is _____
    - Their number is _____

Free help in other languages and formats

Everyone has a right to know about PacificSource Community Solutions' 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: https://pacificsource.com/medicaid/your-plan/member-handbook. If you need help or have questions, call Customer Service at 800-431-4135.

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

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

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

You can ask for materials electronically. Email us at CommunitySolutionsCS@PacificSource.com, or sign in to chat with us electronically at InTouch.PacificSource.com/Members/Account/SignIn. You can also call Customer Service at 800-431-4135.

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 help, please call us at 800-431-4135 (TTY: 711) or call OHP Client Services at 800-273-0557 (TTY: 711). See page 115 for "Complaints, Grievances, Appeals and Fair Hearings" 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 800-431-4135 or TTY: 711. We accept all relay calls.

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 800-431-4135 o TTY: 711. Aceptamos todas las llamadas de retransmisión.

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. 800-431-4135 или TTY: 711. Мы принимаем звонки по линии трансляционной связи.

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 800-431-4135 hoặc TTY (Đường dây Dành cho Người Khiếm thính hoặc Khuyết tật về Phát âm) TTY: 711. Chúng tôi chấp nhận các cuộc gọi chuyển tiếp.

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 800-431-4135 أو المبرقة الكاتبة TTY: 711. نستقبل المكالمات المحولة.

-

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 800-431-4135 ama TTY TTY: 711. Waa aqbalnaa wicitaanada gudbinta.

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 800-431-4135 **或** TTY: 711。**我**们会接听所有的转接来电。

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 800-431-4135 或聽障專線 TTY: 711。我們接受所有傳譯電話。

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. 800-431-4135 또는 TTY: 711 에 전화하십시오. 저희는 중계 전화를 받습니다.

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 800-431-4135 los sis TTY: 711. Peb txais tej kev hu xov tooj rau neeg lag ntseg.

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

Marshallese

Kwomaroñ bōk peba in ilo kajin ko jet, kōn jeje ikkillep, ilo braille ak bar juon wāwein eo eṃṃanḷọk ippaṃ. Kwomaroñ kajjitōk bwe juon ri ukōt en jipañ eok. Ejjeḷọk wōṇāān jipañ in. Kaaltok 800-431-4135 ak TTY: 711. Kwomaroñ kaaltok in relay.

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 800-431-4135 ika TTY: 711. 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 800-431-4135 o TTY: 711. 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 800-431-4135 oder per Schreibtelefon an TTY:711. 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 800-431-4135 ou use o serviço TTY: 711. Aceitamos encaminhamentos de chamadas.

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。800-431-4135 または TTY: 711 までお電話ください。電話リレーサービスでも構いません。

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 800-431-4135 або телетайпу TTY: 711. Ми приймаємо всі дзвінки, які на нас переводять.

Ви можете отримати допомогу від сертифікованого та кваліфікованого медичного перекладача.

Our nondiscrimination policy

PacificSource Community Solutions 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
- Protected class
- Ethnicity
- 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 PacificSource Community Solutions in any of these ways:

- Phone: Call our Grievance Coordinator at 800-431-4135 (TTY: 711)
- Fax: 541-322-6424
- Mail: PacificSource Community Solutions
  Attn: Appeals and Grievances
  P.O. Box 5729
  Bend, OR 97708
- Email: newappeal@pacificsource.com
- Web:

https://pacificsource.com/medicaid/your-plan/member-documents-and-forms

Need help filing a complaint? Call Customer Service at 800-431-4135 or 541-330-2507, (toll-free at 888-970-2507) to speak with a personal health navigator. 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: https://www.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: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
- Phone: 800-368-1019, TDD: 800-537-7697
- Email: OCRMail@hhs.gov
- Mail: Office for Civil Rights
  200 Independence Ave. SW, Room 509F, HHH Bldg.
  Washington, DC 20201

We keep your information private

We only share your records with people who need to see them. This could be for treatment 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. Visit https://pacificsource.com/medicaid/your-plan/member-documents-and-forms to find the form. You can ask us for a list of who we have shared your records with. Please send it to:

PacificSource Community Solutions
PO Box 5729
Bend, OR 97708

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 at 800-431-4135 (TTY: 711) and ask for our Notice of Privacy Practices. You can also see it at https://pacificsource.com/privacy-policy.

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 primary care provider
  - Dental records from your dental care provider
  - Records from PacificSource Community Solutions

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.

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Welcome to PacificSource Community Solutions!

We are glad you are part of PacificSource Community Solutions. PacificSource Community Solutions is happy to help with your health. We want to give you the best care we can.

It is important to know how to use your plan. This handbook tells you about our company, how to get care, and how to get the most from your benefits.

How OHP and PacificSource Community Solutions 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.

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 pages 20-22.

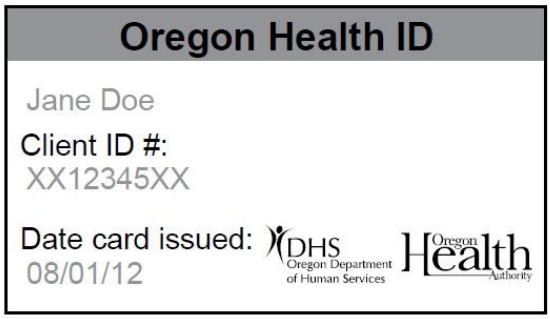
OHP has local health plans that help you use your benefits. The plans are called coordinated care organizations or CCOs. PacificSource Community Solutions is a CCO. PacificSource Community Solutions serves members who live in Hood River and Wasco counties.

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 800-431-4135 (TTY: 711).

All CCOs offer the same OHP benefits. Some offer extra services like new baby items and gym memberships. Learn more about PacificSource Community Solutions' benefits on page 35.

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 PacificSource Community Solutions' member and lists other information like important phone numbers. Your primary care provider (PCP) will also be listed on your ID card.

Your PacificSource Community Solutions' ID card will look like this:

Be sure to show your PacificSource Community Solutions' ID card each time you go to an appointment or the pharmacy.

Your coverage letter and PacificSource Community Solutions' 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 PacificSource Community Solutions' Customer Service Department is open:

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

We're closed on New Year's Day (01/01/24), Memorial Day (05/27/24), Independence Day (07/04/24), Labor Day (09/02/24), Thanksgiving (11/28/24), Friday after Thanksgiving (11/29/24), and Christmas (12/25/24).

Our office location is:
PacificSource Community Solutions
2965 NE Conners Avenue
Bend, OR 97701
Call toll free: 800-431-4135 (language access as well), or TTY: 711. We accept all relay calls.
Fax: 541-322-6423.

Online: https://pacificsource.com/medicaid

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

Important phone numbers

- Medical benefits and care
  Call Customer Service: 800-431-4135, TTY: 711. We accept all relay calls.
  Hours:
  - October 1 – January 31, 7 days a week, 8:00 a.m. to 8:00 p.m.;
  - February 1 – September 30, Monday through Friday, 8:00 a.m. to 5:00 p.m.

  Learn about medical benefits and care on page 39.

- Pharmacy benefits through PacificSource Community Solutions and CVS Caremark
  Call Customer Service: 800-431-4135 (TTY: 711).
  Hours:
  - October 1 – January 31, 7 days a week, 8:00 a.m. to 8:00 p.m.;
  - February 1 – September 30, Monday through Friday, 8:00 a.m. to 5:00 p.m.

  Learn about pharmacy benefits on page 89.

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

  Columbia Gorge:
  Hood River County
  Mid-Columbia Center for Living
  1610 Woods Ct.
  Hood River, OR 97031
  Call 24-hours a day, 7 days a week. Or call 911. 541-386-2620 Local
  8:30 a.m. – 5:00 p.m., Monday – Friday

  CRISIS:
  Crisis Team: 888-877-9147
  Crisis Text Line: text “home” to 741741
  Oregon Youth Line: 877-968-8491

  Wasco County
  Mid-Columbia Center for Living
  1060 Webber St.
  The Dalles, OR 97058
  541-296-5452 Local
  8:30 a.m. – 5:00 p.m., Monday – Friday

  CRISIS:
  Crisis Team: 888-877-9147
  Crisis Text Line: text “home” to 741741
  Oregon Youth Line: 877-968-8491

  PORTLAND CRISIS:
  Multnomah County Crisis: 800-716-9769
  Clackamas County Crisis: 503-655-8585
  Washington County Crisis: 503-291-9111
  Clark County Crisis: 800-686-8137

  PacificSource Community Solutions’ Customer Service: 800-431-4135 (TTY: 711).
  We accept all relay calls.
  Hours: Monday through Friday, 8:00 a.m. to 5:00 p.m.
  Learn about behavioral health benefits on page 59.

- Dental benefits and care

PacificSource dental benefits are provided through our partner dental care plans which are also called Dental Care Organizations (DCOs). PacificSource works with three dental care plans. Call the DCO listed on your welcome letter included with your member ID card to find out what dentist you can see for care. If you want to change your dentist, ask the DCO when you call. If they can't help you or you want to change your DCO, call PacificSource Customer Service.

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

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

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

Learn about dental benefits on page 64.

- Free rides to physical care, dental care, or behavioral health care
  You can get a free ride to physical care, dental care, and behavioral health visits. Call ModivCare at 855-397-3617 to set up a ride. TTY users, please call 711. Hours: Monday through Friday, 9 a.m. to 5 p.m. Your ride provider may be closed on the following holidays: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day. 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. Learn more about rides to care on page 83.

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: 800-699-9075 toll-free (TTY 711)
- Web: OHP.Oregon.gov

- Email: Use the secure email site at https://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 PacificSource Community Solutions 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 800-431-4135.

You have the right to exercise your member rights without a bad response or discrimination. You can make a complaint if you feel like your rights have not been respected. Learn more about making complaints on page 115. You can also call an Oregon Health Authority Ombudsperson at 877-642-0450 (TTY 711). You can send them a secure email at http://www.oregon.gov/oha/ERD/Pages/Ombuds-Program.aspx.

There are times when people under age 18 (minors) may want or need to get health care services on their own. To learn more, read "Minor Rights: Access and Consent to Health Care." This booklet tells you the types of services minors can get on their own and how their health records may be shared. You can read it at OHP.Oregon.gov. Click on "Minor rights and access to care." Or go to: https://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:
    - Care for you,
    - Punish you, or
    - 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 page 2)
- 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 page 12)
    - Have access to your health records
    - 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 PacificSource Community Solutions. (See page 30)
- Be told in a timely manner if an appointment is cancelled.

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 page 87)
- 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 page 2). 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 page 35).
- Urgent and emergency services 24 hours a day, 7 days a week without approval or permission. (See page 92).
- Referrals to specialty providers for covered coordinated services that are needed based on your health. (See page 38).
- Extra support from an OHP Ombudsperson. (See page 23)

You have the right to do these things

- Choose your providers and to change those choices. (See page 27)
- Get a second opinion. (See page 30)
- 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 page 110).
- Make a complaint or ask for an appeal. Get a response from PacificSource Community Solutions when you do this. (See page 115)
    - Ask the state to review if you don't agree with PacificSource Community Solutions' decision. This is called a hearing.
- Get free certified or qualified health care interpreters for all non-English languages and sign language. (See page 2)

Your responsibilities as an OHP member

You must treat others this way

- Treat PacificSource Community Solutions' 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:

- Move or change your mailing address.
- If any family moves in or out of your home.
- Change your phone number.

- Become pregnant and when you give birth.
- 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 PacificSource Community Solutions.
- 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 PacificSource Community Solutions 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 PacificSource Community Solutions 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 (IHS) clinics. Find a clinic at https://www.ihs.gov/findhealthcare/

- Native American Rehabilitation Association of the Northwest (NARA). 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 on page 35.

American Indian and Alaska Natives don't need a referral or permission to get care from these providers. These providers must bill PacificSource Community Solutions. 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 PacificSource Community Solutions any time and have OHP Fee-For-Service (FFS) pay for their care. Learn more about leaving or changing your CCO on page 105.

New members who need services right away

Members who are new to OHP or PacificSource Community Solutions 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 PacificSource Community Solutions:

- Call Care Coordination at 888-970-2507. They can help you get the care you need. Care coordination can help OHP members with Medicare, too. (See page 33 for Care Coordination)
- Make an appointment with your PCP as soon as you can. You can find their name and number on your PacificSource Community Solutions' ID card.
- Call Customer Service at 800-431-4135 if you have questions and want to learn about your benefits. They can help you with what you need.

Primary care providers (PCPs)

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

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

To find a PCP who is currently accepting new members, please review our Provider Directory or contact our Customer Service Department for assistance.

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 PacificSource Community Solutions about a dentist, mental health provider, and pharmacy. Learn more about how to locate a provider in the Provider Directory section below.

Dental Care Organizations (DCOs) and Primary Care Dentists (PCDs)
PacificSource assigns you to a Dental Care Organization (DCO) which is listed on your welcome letter and on your member ID card. Your DCO will either automatically assign you to a primary care dentist (PCD) or they will allow you to choose a PCD. If you want to choose a different PCD, call your DCO for help choosing a PCD that best meets your needs. You may also search for a PCD using PacificSource's Provider Directory at: https://providerdirectory.pacificsource.com/medicaid. Remember that if your DCO assigned you to a PCD, you will need to call them to change your PCD. Each member of your family should have dentist that will be their primary care dentist (PCD). You will go to your PCD for most of your dental care needs. Your PCD will send you to a specialist if you need to go to one. If you want to choose a different PCD, you can call your DCO for help choosing a PCD that best meets your needs.

Your PCD is important because they:

- Are your first contact when you need routine, specialty, urgent, or emergency dental care.
- Manage your dental health services and treatments.
- Arrange your specialty care.

Please call Customer Service at 800-431-4135 (TTY: 711), Monday through Friday, 8:00 a.m. to 5:00 p.m., if you would like to change your PCP. For PCD changes, please call your assigned DCO. To change you assigned DCO, please call PacificSource. You can start seeing your new PCP, PCD or other providers on the day this change is made.

In-network providers

PacificSource Community Solutions 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 page 105)
- You are American Indian or Alaskan Native. (See page 26)

Provider directory

You can choose your PCP, PCD, or other providers from the Provider Directory at: https://providerdirectory.pacificsource.com/medicaid. You can also call Customer Service for help or go to https://pacificsource.com/medicaid to search.

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 800-431-4135 (TTY: 711).

Make an appointment

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

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

Before your appointment, write down:

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

Call for an appointment during office hours and tell them:

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

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

You can get a free ride to your appointment. Learn more about free rides to care on page 83.

Missed appointments

Try not to miss appointments. If you need to miss one, call your PCP or PCD 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. PacificSource Community Solutions offers these options for members who want to change their PCP:

- Visit our online provider directory here: https://providerdirectory.pacificsource.com/medicaid. After you are here,
    - Select the PCP you would like to change to, then
    - Set as my PCP
- Visit InTouch portal for members: https://intouch.pacificsource.com/common/. After you are here,
    - Select Tools, Find a doctor, then search for a PCP, and set as my PCP.
- Contact PacificSource Community Solutions' Customer Service at 800-431-4135 (TTY: 711) for help

Changes to PacificSource Community Solutions' providers

We will tell you when one of your regular providers stops working with PacificSource Community Solutions. 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 PacificSource Community Solutions' 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 PacificSource Community Solutions' Customer Service for help. We will arrange the second opinion for free.

Survey about your health

Shortly after you enroll, then annually unless a change in your health status requires a new assessment, PacificSource Community Solutions will mail you a survey about your health. You can complete the survey by mailing to the address on page 1 or the address on the postage paid return envelope included with your survey. You can also 888-970-2507 to have a care coordination team member help you complete it.

The survey asks questions about your general health, with the goal of helping reduce health risks, maintaining health, and preventing 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.
- Connecting you with services in your area.

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 page 33 for Care Coordination.

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

If we do not get your survey, 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 PacificSource Community Solutions' Customer Service at 800-431-4135, and we will send you one.

Your survey may be shared with your doctor or other providers. PacificSource Community Solutions 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, PacificSource Community Solutions 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: https://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.** Please call PacificSource Community Solution's Customer Service toll-free at 800-431-4135 to ask about your pregnancy benefits. These may include dental and vision services during and after pregnancy.

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 PacificSource Community Solutions.
- ☐ **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 check-up, newborn tips, and resources.

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, cleanings, sealants, and topical fluoride varnish
- Mammograms (breast X-rays) for women
- Pregnancy and newborn care
- Women's annual exams
- 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 800-431-4135 (TTY: 711). We accept all relay calls.

Get help organizing your care with Care Coordination

You get Care Coordination from your patient-centered primary care home (PCPCH), primary care provider, PacificSource Community Solutions, or other primary care teams. You or someone speaking on your behalf can ask for Care Coordination at any time. Call the number below or visit https://pacificsource.com/medicaid/get-care/member-support-specialists for more information about care coordination.

PacificSource Community Solutions has staff members that are part of your care coordination team. PacificSource Community Solutions' staff members 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 them.

Working together for your care

Your care coordinator team will partner with you to:

- 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 coordination team can help you find and navigate other resources in your community, like help for non-medical needs. Some examples are:

- Housing supports.
- Help with rent and utilities.

- Nutrition services.
- Rides.
- Trainings and classes.
- Family support.
- Social services.
- Devices for extreme weather conditions.

The purpose of Care Coordination 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 coordination 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. 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.

Care Coordination availability

Care Coordination services are available Monday through Friday 8:00 a.m. to 5:00 p.m.

- Call PacificSource Community Solutions' Member Support Specialists (MSS) at 888-970-2507 to get more information about Care Coordination.

PacificSource Community Solutions will send you a letter upon enrollment to let you know who your primary care provider is. We will work with the primary care provider team to assist you in coordinating your care and services.

Members with Medicare

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

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 page 76 for more information on coverage for members under 21.

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

Direct Access

You have “direct access” to providers when you do not need a referral or preapproval for a service. You always have direct access to emergency and urgent services. 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**
- **Inpatient Substance Use Disorder Residential and Detox services**
- **Medication Assisted Treatment for Substance Use Disorder**
- **Outpatient and Peer-Delivered Behavioral Health services**
  From an in-network provider
- **Care Coordination services**
  Available for all members
- **Peer Delivered Services**

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, PacificSource Community Solutions 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 PacificSource Community Solutions. PacificSource Community Solutions 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 PacificSource Community Solutions' Customer Service at 800-431-4135 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. Prior authorizations for medications are made within 72 hours, and most within 24 hours of the request. You have the right to complain if you don’t agree with an extension decision. See page 115 to learn 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 page 89 to learn about prescriptions.

You do not need approval for emergency or urgent services or for emergency aftercare services. See page 93 to learn about emergency services.

Services that need preapproval

- **Inpatient Hospital Services**
- **Out-of-network Substance Use Disorder services**
- **Partial or complete dentures**
- **Crowns**
- **Root canal therapy on molars**

PacificSource Community Solutions may require preapproval for services that are not listed here.

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 PacificSource Community Solutions for approval.

If there is not a specialist close to where you live or a specialist who works with PacificSource Community Solutions (also called in-network), they may have to work with the Care Coordination team to find you care out-of-network. There is no extra cost if this happens.

A lot of times your PCP can perform the services you need. If you think you might need a referral to a health care specialist, ask your PCP. You do not need a referral if you are having an emergency.

Services that need a referral

- **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 on page 29.

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 your DCO's network unless your DCO has assigned you to a PCD. If you have an assigned PCD, call your DCO and they can help you change your PCD.
- Family planning services
- Mental health services for problems with alcohol or other drugs
- Assertive Community Treatment

Preapproval 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 preapproval to get a service.

Benefits charts icon key

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

Physical health benefits

See below for a list of medical benefits that are available to you at no cost. Look at the "Service" column to see how many times you can get each service for free. Look at the "How to access" column to see if you need to get a referral or preapproval for the service. PacificSource Community Solutions will coordinate services for free if you need help. If you see an * in the benefit charts, this means a service may be covered beyond the limits listed for members under 21 if medically necessary and appropriate. Please see page 76 to learn more.

Service	How to access	Who can get it?
Care Coordination Services A team that includes your providers, PacificSource staff, and other care teams to help support you with your care needs. Some examples include: • Helping you understand your benefits and how they work • Helping you find providers and get appointments • Assisting with transition of care • Creating care plans that meet your needs	 No referral or preapproval	All members

Service	How to access	Who can get it?
• Connecting you with resources for non medical needs like housing supports and nutrition services See page 33 for more information and a full list of examples. No limits to care.		
Alternative Care • Acupuncture • Chiropractic • Massage • Yoga Alternative care services are limited to treatment of a covered illness or injury. Visits are limited to a combined total of 30 visits of alternative care and traditional therapies. Combined visits in excess of 30 require prior approval and are subject to medical necessity review.	 Some services need to be approved in advance. Please call Customer Service to find out what services need approval in advance.	All members
Ambulance Services We cover ambulance services for one-way transportation during emergencies only. We also cover non-emergent medical transportation (NEMT) for medically necessary covered services.	 No prior approval is needed for emergency transportation.	All members
Comfort Care & Hospice Services (see page 48, Hospice section of benefits chart) Services to comfort a person who is dying and to help their family. Hospice is flexible and can be pain	 Some services need to be approved in	All members

Service	How to access	Who can get it?
treatment, counseling and respite care. Comfort care services are covered for patients with a life-threatening or serious progressive illness to alleviate symptoms and improve quality of life. Hospice services are covered for clients who have been certified as terminally ill. Coverage is based on the OHP Guidelines and certain requirements must be met to receive services.	advance. Please call Customer Service to find out what services need approval in advance.	
Death with Dignity (assisted death for terminally ill) A physician-facilitated death. Covered by OHP Services must be performed by an attending physical or consulting physician.	 Some services need to be approved in advance. Please call Customer Service to find out what services need approval in advance.	All members
Diabetes Prevention Program This program helps those with prediabetes to reduce the risk of type 2 diabetes and improve overall health. This program is available online or in person in a group setting.	 No referral or preapproval	All members

Service	How to access	Who can get it?
Diagnostic Services Diagnostic Radiological Services and Medical Studies Exams such as MRIs and PET scans Lab Services X-ray Services Access to Diagnostic Services is unlimited if medically necessary	 Some services need to be approved in advance. Please call Customer Service to find out what services need approval in advance.	All members
Dialysis Services to treat kidney disease, including outpatient and inpatient dialysis treatments. Certain home support services, for example, visits from trained dialysis workers to check on home dialysis. Certain drugs for dialysis are covered under your drug benefit. Approval based on OHP guidelines. Contact your medical plan.	 Some services need to be approved in advance. Please call Customer Service to find out what services need approval in advance.	All members
Drug and Alcohol Treatment We cover: • Assessment/ evaluation services • Case management • Emergency services • Hospitalization • Detoxification • Residential and day treatment • Medication management • Counseling/Outpatient drug and alcohol services	 No referral is required for drug and alcohol services. Some services may require approval. Contact Customer Service for details.	All members

Service	How to access	Who can get it?
• Office visits and treatment There are no limits on medically necessary drug and alcohol treatment benefits.		
Durable Medical Equipment (DME) and Supplies Some examples are: • Medical supplies (including diabetic supplies) • Medical appliances • Prosthetics and orthotics The following are some examples of DME covered without approval in advance: • Oxygen and oxygen equipment/supplies • Some diabetic supplies, such as glucose test strips (subject to quantity limits) with prescription • Power wheelchairs DME and supplies are covered when medically necessary.	 Some equipment and supplies need to be approved in advance. Please call Customer Service to find out which items need approval in advance. DME may be covered if it is approved for treatment of a covered illness or injury.	All members
***Well-Child Care, Early & Periodic Screening, Diagnosis and Treatment (EPSDT) services** EPSDT services are specifically for screening and assessments of both physical and mental health development. **Children's Care (age 20 and younger)** • Well Child Visits • Shots	 Some services need to be approved in advance. Please call Customer Service to find out what services need approval in advance.	*Members ages 0-20 years old

Service	How to access	Who can get it?
• Newborn Care • Eye Care and Eyeglasses All medically necessary and medically appropriate services for members under 20 and under, including screenings and assessments of physical and mental health development care covered. See page 76 for more information.		
Emergency Care/Services Emergency Department Visits We cover emergency care within the United States.	 No referral or preapproval	All members
Emergency Medical Transportation Using an ambulance or life flight to get medical care. See Ambulance Services above	 No prior approval is needed for emergency transportation.	All members
Family Planning Services Family planning is a service to prevent or delay a pregnancy at no cost to you. Some examples are birth control and annual exams. You can see both in and out-of-network providers for these services We cover • Women's health provider, PCP, or other provider for	 No referral or preapproval This means you have direct access to these services. Some services or procedures require	All members

Service	How to access	Who can get it?
routine and preventive health care services • Birth control education and counseling. • Contraceptive supplies, such as patches, birth control pills, and intrauterine devices (IUDs). • Emergency contraception (the “morning after” pill). • Sterilization (tubal ligations and vasectomies) when performed by an in-network PacificSource provider. • Radiology services (imaging). • Laboratory testing. Related services that are also covered include: • Pap tests. • Pregnancy tests. • Screening and counseling for sexually transmitted diseases (STDs), including AIDS and HIV. • Abortions (Contact OHA by visiting https://www.oregon.gov/oha/ph/healthypeoplefamilies/reproductivesexualhealth/oregoncontraceptivecare/pages/index.aspx#abortion). There are no limits when you see any provider who accepts your ID card for this service and it is medically necessary.	an order from your PCP or specialist. Abortions: Covered by OHP directly (see reference in first column). Please contact the Acentra Care Coordination Team at 800-562-4620.	

Service	How to access	Who can get it?
IMPORTANT! Hysterectomies are not covered as a part of family planning.		
Gender Affirming Care Gender-affirming care means a procedure, service, drug, device or product that a physical or behavioral health care provider prescribes to treat an individual for incongruence between the individual's gender identity and the individual's sex assigned at birth. We cover medically necessary: • Hormone therapy • Top Surgery • Bottom Surgery • Facial Confirmation Surgery • Gender Affirming Hair Removal, including both electrolysis and laser hair removal • Voice and Communication Therapy	 Some services need to be approved in advance. Please call Customer Service to find out what services need approval in advance. We have specific care management support for members trying to access gender affirming care. Please contact Customer Service and request to be referred to the Gender Affirming Care Team.	All members
Hearing Services Some examples are audiology and hearing aids. **Hearing Exam** In a 12-month period, you are eligible for:	 No referral or preapproval	All members

Service	How to access	Who can get it?
• One basic hearing test. • One comprehensive hearing test. • One hearing aid evaluation and selection. • One electroacoustic evaluation for hearing aid: for one or both ears. • One pure tone hearing (threshold) test; air bone.		
Hearing Aids We cover up to 60 hearing aid batteries per hearing aid, every 12 months. For hearing aid batteries to be covered, you need to meet the hearing aid prior authorization requirements.	 Services must be approved in advance. Adults: If you meet prior authorization requirements, you may be covered for one hearing aid for each ear every five years. Children through age 20: If you meet prior authorization requirements, you may be covered for one hearing aid for each ear every three years.	All members
Home Health Services Home Healthcare Examples include home health aide services, occupational therapy,	 With in-network providers, does not	All members

Service	How to access	Who can get it?
physical therapy, skilled nursing, speech therapy. Unlimited when medically necessary.	need approval in advance.	
Hospice (care for terminally ill) Care for terminally ill patients to help with pain and suffering at the end of life. Unlimited when medically necessary.	 With in-network providers, does not need approval in advance.	All members
Hospital Care In-patient care that requires admission to a hospital. Unlimited when medically necessary.	 Some services must be approved in advance for treatment of a covered illness or injury.	All members
Immunizations and Travel Vaccines Certain shots are covered, like flu and preventive shots. Please call Customer Service if you have questions on which shots are covered. Immunizations are not covered for travel or employment purposes.	 No referral or preapproval	All members
Inpatient Hospital Services Some services or items may be limited based on medical necessity, coverage and OHP guidelines.		All members

Service	How to access	Who can get it?
Covered services may include: • Semi-private or private rooms • Meals • Nursing services • Tests and x-rays • Necessary supplies and medication • Physical, occupational, and speech therapy • Inpatient substance abuse services	Preapproval needed	
Interpreter Services You can ask for a healthcare interpreter, sign language and written interpreters, or auxiliary aids and services.This is a free service. See page 4 for more information.	 No referral or preapproval	All members
Laboratory Services, X-Rays, and other procedures Services and tests to diagnose conditions. Laboratory services may include things like blood or urine collections. X-rays are diagnostic services used to generate images of tissues and, bones, and organs inside the body.	 No referral or preapproval	All members
Long-term Care services (covered by OHP) For more information, visit this link: https://www.oregon.gov/oha/PHE/Documents/Oregon-Health-Plan-and-Long-Term-Care.pdf	 No referral or preapproval	All members

Service	How to access	Who can get it?
Maternity Services (Pregnancy care) Extra care and services to help keep you and your baby healthy. Examples include: • Prenatal care (care for you before your baby is born) • Labor and delivery • Postpartum care (care for you after your baby is born) • Doula services • Care for your newborn baby until they are 1 year old • Eye exams and new glasses Unlimited for prenatal care and labor and delivery. See page 32 for more information.	 No approval/referral required for most services. No approval/referral required for eye care appointments during pregnancy. Some eye care products/items do require approval in advance.	Pregnant members
Rides to care. Also called Non-Emergent Medical Transportation (NEMT) Services Transportation to any physical, dental, pharmacy, or behavioral health visit that is covered by PacificSource Community Solutions. See page 83 for more information. This is a free service. Unlimited.	 No referral or preapproval	All members
Outpatient Hospital Services Services that do not require admission to the hospital. This generally means you do not need to spend the night in the hospital and can leave when your procedure is over.	 No referral or preapproval when medically necessary	All members

Service	How to access	Who can get it?
Some examples are: • Chemotherapy • Radiation • Pain Management Unlimited.		
Pharmaceutical Services (Prescription Medications) Medications prescribed by your provider. See the Medications section (page 89) for information.	 Prescription needed	All members
Physical Therapy, Occupational Therapy, Speech Therapy These therapy services are limited to treatment of a covered illness or injury. Physical therapy and/or occupational therapy visits are calculated on a 12- month calendar year. Visits are limited to a combined total of 30 visits of alternative care and traditional therapies. Combined visits in excess of 30 require prior approval and are subject to medical necessity review. Spinal cord injuries, traumatic brain injuries, or cerebral vascular accidents are not subject to the visit limitations during the first year after an acute injury.	 Some services need to be approved in advance. Please call Customer Service to find out what services need approval in advance. Initial evaluations and re- evaluations do not require prior authorization, but are limited to: • Up to two initial evaluations in a 12-month period. • Up to four re-evaluations in a 12-month period.	All members

Service	How to access	Who can get it?
Preventive Services Covered once every 12 months. Some examples are: • Physical Examinations • Well-baby care • Immunizations • Women's health (mammogram, gynecological exam, etc.) • Screenings (cancer, etc.) Digital rectal exam covered once per year. Pap Tests: Once every 3–5 years unless you have had an abnormal result or considered high risk (then it's covered based on your doctor's recommendation). • Pelvic and Clinical Breast Exams: One exam every 12 months (for women). Colon Cancer Screening: you will need an order from your PCP or specialist. Prostate Cancer Screening: you will need an order from your PCP or specialist.	 You do not need a referral for this service.	All members
Primary Care Provider (PCP) Visits Unlimited office visits. Some procedures/treatments must be approved in advance. See page 27 for more information.	 No referral or preapproval	All members

Service	How to access	Who can get it?
Provider Services Office Visits (see PCP and Specialty Care visits sections in benefits chart) In/Outpatient Hospital Visits (see Hospital Care, Outpatient Behavioral Health and Surgery sections in benefits chart) Home Visits (see Home Healthcare in section in benefits chart Psychiatric Emergency Services (PES) please see page 94. Rehabilitative Services: • Physical, Occupational and Speech Therapy (see Physical/Occupational Therapy and Speech Therapy sections of the benefit chart) • Behavioral and Mental Health Services (see this section in the benefit chart) • Alternative Care (see this section in the benefit chart).	 No referral or preapproval	All members
Sexual Abuse Exams This is a medical exam to collect evidence of abuse or assault. This may include a physical exam and/or genital exam. This may also include collection of DNA. Unlimited.	 No referral or preapproval	All members
Shots Medication injected into your body to teach your immune system to recognize and defend against germs and disease.	 You can see any provider that	All members

Service	How to access	Who can get it?
Certain shots are covered, like flu and preventive shots. Please call Customer Service if you have questions on which shots are covered. Not covered for travel or employment purposes.	accepts your ID card for this service. You do not need to be referred by your PCP.	
Skilled Nursing Facility Nursing care and rehabilitation services provided in a medical setting such as a nursing home. Examples of care include physical therapy or injections that can only be given by a nurse or doctor. • Covered for up to 20 days after a covered hospital stay. • If you are also eligible for Medicare, Medicare may cover additional days.	 Admission does not require an approval in advance.	All members
Specialist Services If you have special healthcare needs, you may be referred to a Specialist who has training on that specific area of health care. This could include things such as gastroenterologist, who specializes in digestive organs or an ENT (ear, nose, and throat doctor) who treats sinus problems, hearing and swallowing problems. There are many specialists available that focus on certain conditions. Including second opinions. Office visits are unlimited for a covered condition.	 Preapproval needed	All members For those with special health care needs and those receiving LTSS, no referral is required.

Service	How to access	Who can get it?
Speech Therapy Speech therapy services are limited to treatment of a covered illness or injury. Speech therapy visits are calculated on a 12-month calendar year. Speech therapy visits are limited to a combined 30 visits of traditional and alternative therapy. Additional visits may be approved if medically appropriate. Spinal cord injuries, traumatic brain injuries, or cerebral vascular accidents are not subject to the visit limitations during the first year after an acute injury.	 Some services need to be approved in advance. Please call Customer Service to find out what services need approval in advance. These services do not require an approval in advance: • Up to two evaluations of speech/language in a 12-month period. • Up to two evaluations for dysphagia (difficulty swallowing) in a 12-month period. • Up to four re-evaluations in a 12-month period. • One evaluation for speech-generating/augmentative communication system or device	All members

Service	How to access	Who can get it?
	in a 12-month period. One evaluation per twelve months for human-made voice or voice box device.	
Stop Smoking/Tobacco Cessation Services We pay for medications to help you stop using tobacco products. We will also pay for counseling sessions over the phone, in person, and in groups. For more information, call our Customer Service at 800-431-4135 or the Tobacco Quitline at 800-784-8669.	 No referral or preapproval	All members
Substance Use Disorder Treatment See Drug and Alcohol Treatment. There are no limits on medically necessary substance use disorder treatment benefits.	 No referral is required for substance use disorder treatment. Some services may require approval, but most do not. Contact Customer Service for details.	All members
Surgical Procedures To include: • Surgical Services • Reconstructive surgery		All members

Service	How to access	Who can get it?
Proof of smoking cessation or nonsmoking status may be required prior to certain elective surgical procedures.	Approval in advance is required.	
Telehealth Services Video care or care over the phone instead of going into your providers office. Some examples are: • Telemedical services • Virtual visits • Email visits This is a free service. Please contact your doctor's office or Customer Service for more information. Unlimited. See page 87 for more information.	 No referral or preapproval	All members
Traditional Health Worker (THW) Services Workers that help with questions about healthcare and communication with your providers. They can also help you connect with services in the community. Examples include: • Birth Doulas • Community Health Workers • Personal Health Navigators • Peer Support Specialists • Peer Wellness Specialists • Tribal Traditional Health Workers See page 79 for more information.	 No referral or preapproval	All members

Service	How to access	Who can get it?
Urgent Care Services Urgent Care Visits Services are covered 24-hours a day, 7 days a week, at home or if you are traveling outside the service area within the United States. See page 92 for more information.	 No referral or preapproval	All members
Women's Health Services (in addition to PCP) for routine and preventive care Services that focus on health issues that are unique to women, such as menstruation and pregnancy. Examples include: • Pap tests • Pelvic exams, and • Clinical breast exams For more information, see Preventive Services and Family Planning sections above	 No referral or preapproval	All members
Vision Services **Non-pregnant adults (21+) are covered for:** • Routine eye exams at least every 24 months and when needed • Medical eye exams when needed ○ Corrective lenses / accessories only for certain medical eye conditions If you have a qualifying medical condition or have been diagnosed with one of the conditions listed	 Some services or procedures may require an order from your PCP or specialist and may require approval in advance.	All members who are not pregnant and age 21 and older

Service	How to access	Who can get it?
below, eye exams and eyeglasses may be covered: • Aphakia • Pseudo Aphakia • Keratoconus • Congenital Cataracts • Corneal Transplant **Members under 21, pregnant adults, adults up to 12 months post-partum are covered for:** • Routine eye exams every 24 months and when needed • Medical eye exams when needed • Corrective lenses / accessories when needed Examples of medical eye conditions are aphakia, keratoconus, or after cataract surgery.	 No referral or preapproval	*Members ages 0-20 years old, and pregnant members

The table above is not a full list of services that need preapproval or referral. If you have questions, please call PacificSource Community Solutions' Customer Service at 800-431-4135 (TTY: 711).

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. PacificSource Community Solutions will coordinate services for free if you need help. If you see an * in the benefit charts, this means a service may be covered beyond the limits listed for members under 21 if medically necessary and appropriate. Please see page 76 to learn more.

Service	How to access	Who can get it?
Care Coordination Services A team that includes your providers, PacificSource staff, and other care teams to help support you with your care needs. Some examples include: • Helping you understand your benefits and how they work • Helping you find providers and get appointments • Assisting with transition of care • Creating care plans that meet your needs • Connecting you with resources for non medical needs like housing supports and nutrition services See page 33 for more information and a full list of examples. No limits to care.	 No referral or preapproval	All members
Assertive Community Treatment Team-based treatment and support services for members who are diagnosed with serious mental illness. Services and length of treatment are adjusted to meet the needs of each individual member.	 No referral or preapproval is required, but must complete screening	All members over *18 years of age
***Wraparound Services** Care coordination services for members with complex needs and involvement with multiple community programs. Services and length of treatment are adjusted to meet the needs of each individual member.	 No referral or preapproval is required, but provider screening may be required.	*Members aged 0-17 (or those who have continued to receive these services from ages 18-25) with complex needs and have been involved in two or more child-serving systems.

Service	How to access	Who can get it?
Behavioral and Mental Health Services There are no limits on behavioral health benefits. Services and length of treatment are adjusted to meet the needs of each individual member. We cover medically necessary: • Behavioral health assessment and evaluation services, • Case management, • Skills training, • Crisis services, • Behavioral health hospitalization, • Medication management, • Psychiatric residential, • Partial hospitalization programs and day treatment, • Counseling/Outpatient behavioral health services, • Behavioral health peer services, • Medication assisted treatment, • Substance use disorder treatment, • Eating disorder treatment, • Intensive In-Home Behavioral Health Treatment (IIBHT) • Assertive Community Treatment (ACT), • Wraparound Care Coordination, • Early Assessment Support Alliance (EASA), • Supported Employment	 No referral is required for behavioral health services. Some services may require provider screening.	All members

Service	How to access	Who can get it?
Behavioral Health Assessment and Evaluation Services An evaluation where the members need for behavioral health services is determined through review of the strengths, needs, and goals. Services and length of treatment are adjusted to meet the needs of each individual member.	 No referral or preapproval	All members
Behavioral Health Psychiatric Residential Treatment Services (PRTS) Intensive 24-hour level of care that provides a range of Behavioral Health services that cannot be provided in an outpatient setting. Services and length of treatment are adjusted to meet the needs of each individual member.	 No referral or preapproval, but provider screening may be required.	Members under 21 years of age
Inpatient Substance Use Disorder Residential and Detox Services Intensive 24-hour level of care that provides a range of Behavioral Health services that cannot be provided in an outpatient setting. Detox services are short-term, medical services to support members in active withdrawal from alcohol and/or other drugs. Services and length of treatment are adjusted to meet the needs of each individual member.	 No preapproval needed, but provider screening may be required.	All members

Service	How to access	Who can get it?
Medication Assisted Treatment (MAT) for Substance Use Disorder (SUD) The use of medication to treat substance use disorders. Services and length of treatment are adjusted to meet the needs of each individual member.	 Preapproval needed after first 30 days No preapproval required for first 30 days of treatment. May require a referral	All members
Outpatient and peer delivered behavioral health services from an in-network provider Outpatient treatment are services provided in a community-based setting to meet the behavioral health needs of the member. Peer-delivered services are services provided by people living with behavioral health challenges to: • Build personal relationships, • Become socially involved with others, • Plan and problem-solve to get the care they need, • Model a resilient, healthy recovery lifestyle Services and length of treatment are adjusted to meet the needs of each individual member.	 No referral or preapproval	All members

Service	How to access	Who can get it?
Substance Use Disorder (SUD) services Services and supports for members struggling with use of alcohol and/or other drugs. Examples of services and supports include: • Detoxification • Inpatient treatment • Outpatient treatment • Medication-assisted treatment Services and length of treatment are adjusted to meet the needs of each individual member.	 No referral or preapproval	All members

The table above is not a full list of services that need preapproval or referral. If you have questions, please call PacificSource Community Solutions' Customer Service at 800-431-4135 (TTY: 711).

Dental benefits

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

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

- 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 check-up by age 1.
- Infection in your mouth can spread to your heart, brain and body.

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

- Endodontists (for root canals)
- Pedodontist (for adults with special needs, and children)

- Periodontist (for gums)
- Orthodontist (in extreme cases, for braces)
- Oral surgeons (for extractions that require sedation or general anesthesia).

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

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

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. If you see an * in the benefit charts, this means a service may be covered beyond the limits listed for members under 21 if medically necessary and appropriate. Please see page 76 to learn more.

Service	How to access	Who can get it
Care Coordination Services A team that includes your providers, PacificSource staff, and other care teams to help support you with your care needs. Some examples include: • Helping you understand your benefits and how they work • Helping you find providers and get appointments • Assisting with transition of care • Creating care plans that meet your needs • Connecting you with resources for non medical needs like housing supports and nutrition services See page 33 for more information and a full list of examples. No limits to care.	 No referral or preapproval	All members

Service	How to access	Who can get it
Emergency and Urgent Dental care Emergency and urgent dental care means dental services needed to care for emergency and urgent dental conditions. Emergency (immediate) Dental Services for conditions such as: • Extreme tooth or mouth pain • Severe infection or swelling • Bleeding that will not stop • Injuries to the teeth or gums • A knocked-out tooth Urgent Dental Services for conditions such as: • Toothaches • Lost fillings No limits. Examples: extreme pain or infection, bleeding or swelling, injuries to teeth or gums.	 No referral or preapproval.	All members
Oral Exams Dental providers perform oral exams to check the teeth, gums, and mouth for treatment needs. Pregnant members. Twice a year. *Members under 19 years old: Twice a year. *Members 19 years of age and older: Once a year. **In accordance with EPSDT requirements, all medically necessary and medically appropriate dental services are available to members under age 21. This table may not list all available EPSDT services.	 No referral or preapproval	All members

Service	How to access	Who can get it
Oral Cleanings Cleanings are dental services that get rid of debris and other substances that hurt the teeth and gums and cause dental disease if not removed. *Members under 19: Twice a year. Additional cleanings per year may be available for members with certain high-risk conditions. All other members: Once a year. Additional cleanings per year may be available for members with certain high-risk conditions. **In accordance with EPSDT requirements, all medically necessary and medically appropriate dental services are available to members under age 21. This table may not list all available EPSDT services.	 No referral or preapproval	All members
Fluoride varnish Fluoride varnish is a dental treatment that helps prevent tooth decay. It can also help by slowing down existing tooth decay, stopping it from getting worse, and help repair teeth where tooth decay has caused damage or softened the tooth. *Members under 19: Twice a year. Members with certain high-risk conditions may receive additional fluoride applications, up to a total of four applications in a year. Members age 19 and older: Once a year. Members with certain high-risk conditions may receive additional fluoride applications, up to a total of four applications in a year.	 No referral or preapproval	All members
Oral X-rays X-rays or radiographs are images taken of teeth so that dental providers can understand if there is dental disease that needs treatment. Routine x-rays covered once a year.	 No referral or preapproval	All members

Service	How to access	Who can get it
**In accordance with EPSDT requirements, all medically necessary and medically appropriate dental services are available to members under age 21. This table may not list all available EPSDT services.		
Sealants Sealants are thin, protective coatings that are painted on to the surfaces of some teeth to protect against tooth decay. Sealants are not covered for adults. *Sealants are covered for members under age 16, on adult back teeth once every 5 years.	 No referral or preapproval	*Members under age 16
Fillings Fillings means materials that are used to replace the parts of teeth that have been removed because of tooth decay. No limit. **In accordance with EPSDT requirements, all medically necessary and medically appropriate dental services are available to members under age 21. This table may not list all available EPSDT services.	 No referral or preapproval required for basic restorative care (fillings)	All members
Partial or complete dentures Dentures are a type of removable appliance that replaces missing teeth. Partial dentures: Once every 5 years for members who meet OHP qualifying guidelines. Complete dentures: Once every 10 Years for members who meet OHP qualifying guidelines. Your DCO may require authorization for dentures. Contact your DCO.	 Preapproval may be required. Contact your DCO for additional information.	Members age *16 and older

Service	How to access	Who can get it
**In accordance with EPSDT requirements, all medically necessary and medically appropriate dental services are available to members under age 21. This table may not list all available EPSDT services.	 Referral needed if not seeing your primary care dentist	
Crowns Crowns are caps made of various materials that are used to cover and protect a tooth that has had a lot of damage from tooth decay or other reasons. Permanent crowns are covered for certain upper and lower front teeth, for members who meet OHP qualifying guidelines for this service. Coverage is limited to 4 Crowns Every 7 years. Stainless steel crowns are covered only for primary front teeth and for posterior (back teeth, molars) permanent or primary teeth. Certain requirements must be met to receive a crown. Benefits vary by type of crown, specific teeth requiring care, age, and pregnancy status. Contact your dental health plan. **In accordance with EPSDT requirements, all medically necessary and medically appropriate dental services are available to members under age 21. This table may not list all available EPSDT services.	 Preapproval may be required. Contact your DCO for additional information. Referral needed if not seeing your primary care dentist	Pregnant members, or *members between ages 16 through 20.
Extractions Extractions means removing teeth. No limit.	 Referral needed if not seeing your primary care dentist	All members

Service	How to access	Who can get it
Root Canal Therapy Root canal therapy means cleaning out and removing parts of the inside of a tooth that has been damaged by tooth decay or other reasons. Not Covered on Third Molars (Wisdom Teeth). * Members under age 21: Covered for members who meet OHP qualifying guidelines for this service on first and second molars, front teeth, and pre-molars. Pregnant members: Covered for members who meet OHP qualifying guidelines for this service on permanent first molars, front teeth and pre-molars. Your DCO may require authorization for root canal therapy. Contact your DCO. **In accordance with EPSDT requirements, all medically necessary and medically appropriate dental services are available to members under age 21. This table may not list all available EPSDT services.	 Preapproval may be required. Contact your DCO for additional information. Referral needed if not seeing your primary care dentist	Pregnant members and *members under age 21
Orthodontics Orthodontics means dental services to correct severe misalignment of teeth or other severe problems (that cause problems with chewing, speaking or other functions) that may require appliances such as braces or other services. Orthodontic Services for conditions such as: • Cleft lip or cleft palate with cleft lip • Craniofacial malocclusions or anomalies In cases such as cleft lip and palate, or when speech, chewing and other functions are affected. It is required to have approval from	 Preapproval needed	*Members under 21

Service	How to access	Who can get it
your dentist and to not have any cavities or gum disease. Orthodontic services are covered only to treat severe craniofacial anomalies and severe malocclusions for members under age 21 who meet OHP qualifying guidelines. Contact your DCO for additional steps. **In accordance with EPSDT requirements, all medically necessary and medically appropriate dental services are available to members under age 21. This table may not list all available EPSDT services.		

The table above is not a full list of services that need preapproval or referral. If you have questions, please call Customer Service at 800-431-4135 (TTY: 711).

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

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

OHP and PacificSource Community Solutions 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 Pacific Source Community Solutions' Customer Service at 800-431-4135 (TTY: 711).

Services that OHP pays for

PacificSource Community Solutions 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 "noncovered" benefits. There are two types of services OHP pays for directly:

1. Services where you get care coordination from PacificSource Community Solutions.
2. Services where you get care coordination from OHP.

Services with PacificSource Community Solutions' care coordination

PacificSource Community Solutions still gives you care coordination for some services. Care coordination means you will get free rides from ModivCare for covered services, support activities and any resources you need for non-covered services.

PacificSource Community Solutions will coordinate your care for the following services:

- Planned Community Birth (PCB) services, include prenatal and postpartum care for women experiencing low risk pregnancy as determined by the OHA Health Systems Division. OHA is responsible for providing and paying for primary PCB services including at a minimum, for those members approved for PCBs, newborn initial assessment, newborn bloodspot screening test, including the screening kit, labor and delivery care, prenatal visits and postpartum care.
- Long term services and supports (LTSS) not paid by PacificSource Community Solutions
- Family Connects Oregon services, which provide support for families with newborns. Get more information at https://www.familyconnectsoregon.org/.
- Helping members to get access to behavioral health services. Examples of these services are:
    - Certain medications for some behavioral health conditions
    - Therapeutic group home payment for members under 21 years old
    - Long term psychiatric (behavioral health) care for members 18 years old and older
    - Personal care in adult foster homes for members 18 years and older
- And other services

For more information or for a complete list about these services, call Care Management at 888-970-2507 or Customer Service at 800-431-4135 (TTY: 711).

Services that OHP pays for and provides care coordination

OHP will coordinate your care for the following services:

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

Contact OHP's Acentra Care Coordination team at 800-562-4620 for more information and help with these services.

You can still get a free ride from ModivCare for any of these services. See page 83 for more information. Call 855-397-3617 (TTY: 711) to schedule a ride or ask questions.

Moral or Religious objections

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

PacificSource Community Solutions 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.

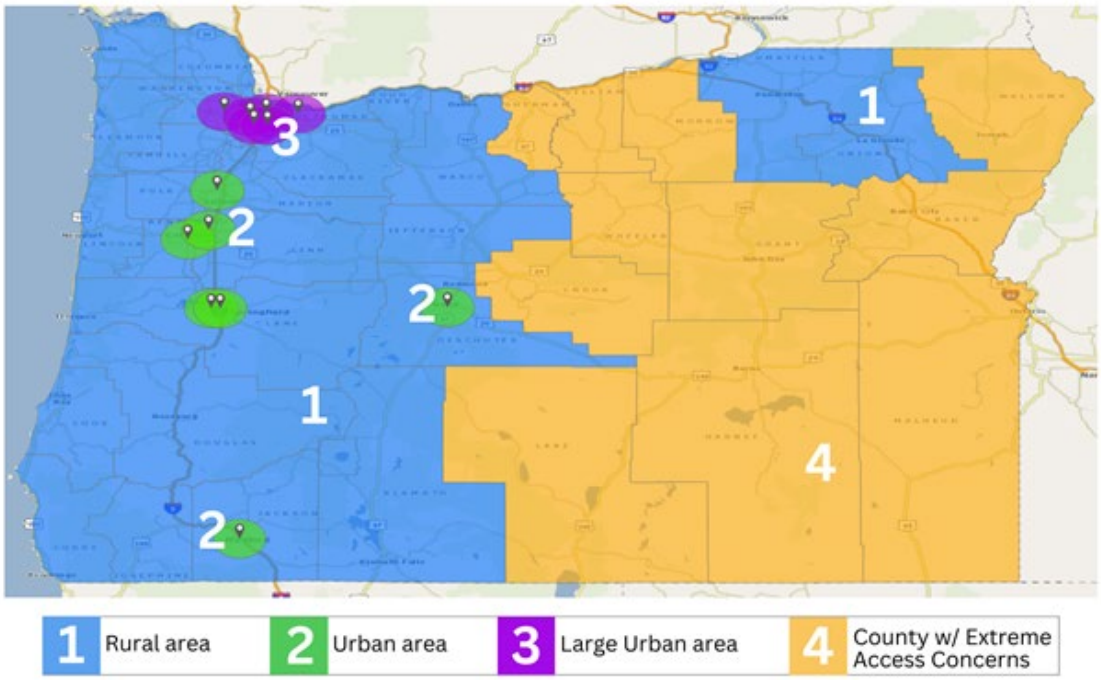
	Large Urban	Urban	Rural	County with Extreme Access Considerations
Tier 1	10 mins or 5 miles	25 mins or 15 miles	30 mins or 20 miles	40 mins or 30 miles
Tier 2	20 mins or 10 miles	30 mins or 20 miles	75 mins or 60 miles	95 mins or 85 miles
Tier 3	30 mins or 15 miles	45 mins or 30 miles	110 mins or 90 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:
https://www.oregon.gov/oha/HSD/OHP/Pages/network.aspx

Not sure what kind of area you live in? See the map below:

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 PacificSource Community Solutions at 800-431-4135 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 4 weeks
Urgent care	Within 72 hours or as indicated in the initial screening.
Emergency care	Immediately or referred to an emergency department depending on your condition.
Oral and dental care for children and non-pregnant people	
Regular oral health appointments	Within 8 weeks unless there is a clinical reason to wait longer.
Urgent oral care	Within 2 weeks.
Dental Emergency services	Seen or treated within 24 hours
Oral and dental care for pregnant people	
Routine oral care	Within 4 weeks unless there is a clinical reason to wait longer.
Urgent dental care	Within 1 week
Dental emergency services	Seen or treated within 24 hours
Behavioral health	
Routine behavioral healthcare for non-priority populations	Assessment within 7 days of the request, with a second appointment scheduled as clinically appropriate.
Urgent behavioral healthcare for all populations	Within 24 hours.
Specialty behavioral healthcare for priority populations*	
Pregnant people, veterans and their families, people with children, unpaid caregivers, families, and children ages 0-5 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.
Care type	Timeframe
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 healthcare services if there is no room or open spot:

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

If you have any questions about access to care, call Customer Service at 800-431-4135 (TTY: 711).

Comprehensive and preventive benefits for members under age 21.

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for OHP members from birth to 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, PacificSource Community Solutions has to give:

- Regularly scheduled examinations and evaluations of physical, mental health, developmental, oral/dental health, growth, and nutritional status.
    - If PacificSource Community Solutions doesn’t cover oral/dental health, you can still get these services through OHP by calling 1-800-273-0557.
- Starting January 1, 2023, all medically necessary and medically appropriate services must be covered for members 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 page 35.

Under EPSDT, PacificSource Community Solutions 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. PacificSource Community Solutions 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 page 115.

This includes *all* services:

- Physical Health;
- Behavioral Health;
- Dental Health; and
- Social Health Care Needs.

If you or your family member needs EPSDT services, work with your primary care provider (PCP) or talk to a care coordinator by calling 800-431-4135 (TTY: 711). They will help you get the care you need. If any services need approval, they will take care of it. Work with your primary care dentist for any needed dental EPSDT services. All EPSDT services are free.

Help getting EPSDT services

- Call Customer Service at 800-431-4135 (TTY: 711). You may also visit our website at: https://pacificsource.com/medicaid.
- PacificSource Community Solutions works with three dental care plans. To set up dental services or for more information, call:
    - **Advantage Dental Services Customer Service:** 866-268-9631 (answered 24 hours, 7 days a week for dental emergencies), TTY: 711
    - **Capitol Dental Care Customer Service:** 800-525-6800 (answered 24 hours, 7 days a week for dental emergencies), TTY: 711
    - **ODS Community Dental Customer Service:** 800-342-0526 , TTY: 711
- You can get free rides to and from covered EPSDT provider visits. Call 800-431-4135 to set up a ride or for more information.
- You can also ask your PCP or visit our website at https://pacificsource.com/medicaid/your-plan/preventive-care-members-under-21 for a copy of the periodicity schedule. This schedule tells you when children need to see their PCP.

Screenings

Covered screening visits are offered at age-appropriate intervals (these include well child visits or adolescent well visits). PacificSource Community Solutions and your PCP follow the American Academy of Pediatrics and Bright Futures guidelines for all preventive care screenings and well child visits. Bright Futures can be found at: https://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 client 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-adolescent.html
    - Adult Immunization Schedule (19+): https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html
- Health guidance and education for parents and children.
- Referrals for medically necessary physical and mental health treatment.
- Needed hearing and vision tests.
- And others.

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

EPSDT 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.

PacificSource Community Solutions or OHP will help with finding a provider, making an appointment, and care coordination.

Screenings may find a need for the following services:

- 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 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 page 115.

PacificSource Community Solutions will give referral help to members or their representatives for social services, education programs, nutrition assistance programs (e.g., SNAP), and other services not covered by EPSDT.

For more information about EPSDT coverage, you can visit www.Oregon.gov/EPSDT and view a member fact sheet. PacificSource Community Solutions also has information at https://pacificsource.com/medicaid/your-plan/preventive-care-members-under-21.

Traditional Health Workers (THWs)

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 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.

You do not need a referral to speak with a THW. There are THWs who are certified as Personal Health Navigators within the PacificSource Member Support Specialist (MSS) team in our Care Management Department. If you would like to speak to a MSS, they can also be reached at 541-330-2507, or toll-free at 888-970-2507.

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

THW Liaison Contact Information:

If you would like to talk with a THW Liaison or be connected to THW services in the community or at your provider's office, please call 541-640-8742.

If we change the contact information for the THW liaison, you can find up-to-date information on our website at: https://pacificsource.com/medicaid/get-care/traditional-health-workers.

Extra services

Health-Related Services

Health-Related Services (HRS) are extra services PacificSource Community Solutions 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 PacificSource Community Solutions' 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 https://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. PacificSource Community Solutions offers these flexible services:

- Fitness classes or punch cards
- Air conditioners during very hot weather
- Emergency housing after hospital discharge

Examples of other flexible services:

- 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
- Items that support healthy behaviors, such as athletic shoes or clothing
- Devices for accessing telehealth or health apps
- Other items that keep you healthy, such as an air purifier or replacement filters

How to get flexible services for you or family member

You can work with your provider to request flexible services or you can call PacificSource Community Solutions' Customer Service at 800-431-4135 and have a request form sent to you in the language or format that fits your needs. The form is also available on our website: https://pacificsource.com/medicaid/your-plan/member-documents-and-forms.

Flexible services are not a covered benefit for members and CCOs are not required to provide them. Decisions to approve or deny flexible service requests are made on a case-by-case basis. If your flexible service request is denied, you will get a letter explaining your options. You can't appeal a denied flexible service, but you have the right to make a complaint. Learn more about appeals and complaints on page 115.

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 https://www.211info.org/ website for help.

Community Benefit Initiatives

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

Examples of PacificSource Community Solutions' Community Benefit initiatives include:

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

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-emotional health and academic learning
- Training for teachers and child-specific community-based organizations on trauma informed practices

Open Access Points

In most regions in Oregon, we have special agreements with Indian Health Care Providers (IHCP) and Indian Health Service clinics (IHS). These special agreements allow our members to be seen in these types of facilities without being assigned to that facility and without a referral.

If you would like to have your oral health care done at one of these types of facilities, you can call the facility and ask if they work with PacificSource or your Dental Plan as an "Open Access Point". You can also call Customer Service and ask for a current list of Open Access Points in your region.

Health Related Social Needs

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

- Housing Services: Help with rent and utilities, to get or keep housing, moving costs, and home modifications. This will begin no sooner than November 1, 2024 and will be for members at risk of becoming houseless. For others, this service will start at a later date.
- Climate Supports: Help to get health related air conditioners, heaters, air filters, mini fridges, and portable power supplies. This will begin March 2024.
- Nutrition Services: Includes nutrition education, medically tailored meals, meals or pantry stocking, fruit and vegetable prescriptions. This will begin January 1, 2025.

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

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

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

You are able to ask to be screened for eligibility or to deny screening for eligibility. If approved, you can choose to receive or not receive HRSN Services. If approved, HRSN Services are free to you and you can opt out at any time. If you receive HRSN Services, your care coordination team will work with you to make sure your care plan includes the services you receive. See page 33 for Care Coordination and care plans.

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

Free rides to care

Free rides to appointments for all PacificSource Community Solutions' members.

If you need help getting to an appointment, call ModivCare at 855-397-3617 (TTY: 711)

for a free ride. You can get a free ride to any physical, dental, pharmacy, or behavioral health visit that is covered by PacificSource Community Solutions.

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

For additional information on mileage, meal, and lodging reimbursement, please contact ModivCare prior to the date of your appointment to discuss the process. Our Rider's Guide can be found here:https://pacificsource.com/sites/default/files/2023-04/MCD126_0423_NonEmergentMedicalTransportRidersGuide.pdf.

Schedule a ride

Call ModivCare at 855-397-3617 (TTY: 711) Hours: Monday through Friday, 9:00 a.m. to 5:00 p.m. for routine trips and 24/7/365 for urgent and discharges. Your ride provider may be closed on the following holidays: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day.

Please call at least 2 business days before the appointment to schedule a ride. This will help make sure we can meet your ride needs.

You can get a same or next-day ride. Please call ModivCare.

You or someone you know can set up more than one ride at a time for multiple appointments. You can schedule rides for future appointments up to 90 days in advance.

What to expect when you call

PacificSource Community Solutions has ride call center staff who can help in your preferred language and in a way that you can understand. This help is free.

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

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

- Your full name.
- Your address and phone number.
- Your date of birth.
- Name of the doctor or clinic you need to visit.
- Date of appointment.
- Time of appointment.
- Pick-up time after appointment.
- If you need an attendant to help you.

- Any other special needs (like a wheelchair or service animal).

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

If you request a ride less than two (2) days before the scheduled pick-up time, we will give you the phone number of the company who will arrange for your pick up. We may also give you the name and phone number of the driver who will pick you up.

Pick up and drop off

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

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

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

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

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

You have rights and responsibilities as a rider:

You have the right to:

- Get a safe and reliable ride that meets your needs.

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

Your responsibilities are to:

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

Cancel or change your ride

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

You can call ModivCare at 855-397-3617 (TTY: 711) Monday through Friday, 9:00 a.m. to 5:00 p.m. for routine trips and 24/7/365 for urgent and discharges. Leave a message if you can't call during business hours. Call ModivCare if you have any questions or ride changes.

When you don't show up

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

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

If your ride is denied

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

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

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

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

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

Learn more about complaints, grievances, appeals and hearings on page 115.

Rider Guide

Get the ModivCare Rider Guide at: https://pacificsource.com/medicaid/get-care/get-ride. You or your representative can also call Customer Service at 800-431-4135 to ask for a paper copy. It will be sent in 5 business days. The paper copy can be in the language and format you prefer.

The guide has more information, like:

- Wheelchairs and mobility help.
- Vehicle safety.
- Driver duties and rules.
- What to do in an emergency or if there is bad weather.
- Long distance appointments.
- Meal and lodging reimbursement.

Getting care by video or phone

Telehealth (also known as telemedicine and teledentistry) is a way for you to get care without going into the clinic or office. Telehealth means you can have your appointment through a phone call or video call. PacificSource Community Solutions will cover telehealth visits. Telehealth lets you visit your provider using a:

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

Medicaid members are eligible for the Assurance Wireless Affordable Connectivity Program (ACP), which includes internet, smartphone, data, and/or cell phone coverage at low or no cost. For more information, please contact Assurance Wireless at 1-888 321-5880 or visit www.assurancewireless.com.

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. To find out if your doctor's office is set up for this, call them or check their website. This information can also be found in our Provider Directory online: https://providerdirectory.pacificsource.com/medicaid.

Many doctors offer "virtual visits" by video chat or phone call. Look for "This provider offers Telemedicine" in your search results (shown below), and contact them to learn which telemedicine services are available.

Your provider cannot require that you only use telehealth services. Access to this type of visit varies by provider. Some of these visits may be over phone. Others may require other apps, such as Zoom. If you need help accessing this service, please call your provider's office for assistance. You can also contact our Customer Service team for help at 800-431-4135 (TTY: 711).

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

When to use telehealth

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

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

Telehealth is not recommended for emergencies. If you feel like your life is in danger, please call 911 or go to the nearest emergency room. See page 91 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) on page 12.

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

You have a right to:

- Get telehealth services in the language you need.
- Have a provider that respects your culture and language needs.
- Get qualified and certified interpretation services. Learn more on page 4.
- Get in-person visits, not just telehealth visits.
    - PacificSource Community Solutions 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 it's disaster plan.
- Get support and have the tools needed for telehealth.
    - PacificSource Community Solutions will help identify what telehealth tool is best for you.

Talk to your provider about telehealth. You can also call Customer Service at 800-431-4135 (TTY: 711). We are open Monday through Friday, 8:00 a.m. to 5:00 p.m.

Prescription medications

To fill a prescription, you can go to any pharmacy in PacificSource Community Solutions' network. You can find a list of pharmacies we work with in our Provider Directory at https://providerdirectory.pacificsource.com/medicaid.

For all prescriptions covered by PacificSource Community Solutions, bring to the pharmacy:

- The prescription.
- Your PacificSource Community Solutions' 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

PacificSource Community Solutions' list of covered medications is at: https://pacificsource.com/medicaid/find-a-drug.

- 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.

- PacificSource Community Solutions 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.

PacificSource Community Solutions also covers some over the counter (OTC) medications when your provider or pharmacy prescribes them for you. You will need a prescription for us to pay for them. OTC medications are those you would normally buy at a store or pharmacy without a prescription, such as aspirin.

Asking PacificSource Community Solutions to cover prescriptions

When your provider asks PacificSource Community Solutions to approve or cover a prescription:

- Doctors and pharmacists at PacificSource Community Solutions 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 PacificSource Community Solutions decides to not cover the prescription, you will get a letter from PacificSource Community Solutions. The letter will explain:

- Reason request was not approved
- 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 PacificSource Community Solutions' Customer Service at 800-431-4135 (TTY: 711) if you have questions.

Mail-order pharmacy

CVS Caremark Mail-Order Services can mail some medications to your home address. This is called mail-order pharmacy. If picking up your prescription is hard for you, mail-order pharmacy may be a good option. Call PacificSource Community Solutions' Customer Service at 800-431-4135 (TTY: 711) to:

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

Refer to our website for a link to setup a Caremark mail order account at https://pacificsource.com/medicaid/get-care/your-medicine.

OHP pays for behavioral health medications

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

- PacificSource Community Solutions and your provider will help you get the medications you need.
- The pharmacy sends your prescription bill directly to OHP. PacificSource Community Solutions 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 PacificSource Community Solutions' Customer Service at 800-431-4135 (TTY: 711).

Prescription coverage for members with Medicare

PacificSource Community Solutions 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 PacificSource Community Solutions' ID card at the pharmacy.

If Medicare Part D does not cover your medication, your pharmacy can bill PacificSource Community Solutions. If OHP covers the medication, PacificSource Community Solutions will pay for it.

Learn more about Medicare benefits on page 104.

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 PacificSource Community Solutions at 800-431-4135 (TTY 711) 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.

Columbia Gorge:
Hood River
Providence Hood River Memorial

810 12th St., Hood River, OR 97031
541-386-3911 (TTY: 711)
https://Oregon.Providence.org/location-directory/p/ providence-hood-river-memorial-hospital

The Dalles
Mid-Columbia Medical Center
1700 E 19th St., The Dalles, OR 97058
541-296-1111 (TTY: 711)
https://MCMC.net

Urgent care

An urgent problem is serious enough to be treated right away, but it's not serious enough for immediate treatment in the emergency room. These urgent problems could be physical, behavioral or dental.
You can get urgent care services 24 hours a day, 7 days a week without preapproval. You do not need a referral for urgent or emergency care. For a list of urgent care centers and walk-in clinics see below. Urgent dental care information can be found on page 93.

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).

You can call anytime, day or night, on weekends and holidays. Tell the PCP office you are a PacificSource Community Solutions' member. You will get advice or a referral. If you can't reach your PCP about an urgent problem or if your PCP can't see you soon enough, go to an urgent care center or walk-in clinic. You don't need an appointment. See below list of urgent care and walk-in clinics.

If you need help, call PacificSource Community Solutions' Customer Service at 800-431-4135 (TTY: 711).

If you don't know if your problem is urgent, still call your provider's office, even if it's closed. You may get an answering service. Leave a message and say you are a PacificSource Community Solutions' member. You may get advice or a referral of somewhere else to call. You will get a call back from a PacificSource Community Solutions' representative within 30-60 minutes after you called, to talk about next steps.

You can also call our 24-Hour NurseLine for help anytime of the day or night at 855-834-6150. This phone number is listed on the back of your membership card.

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

Urgent care centers and walk-in clinics in the PacificSource Community Solutions' area:

Wasco County

MCMC Immediate Care at Water's Edge
551 Lone Pine Blvd., The Dalles, OR 97058
541-506-5880 (TTY: 711)
https://www.MCMC.net/our-services/immediate-care

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 your DCO on page 22. They will help you find urgent dental care, depending on your condition. You should get an appointment within 2 weeks, or 1 week if you're pregnant, for an urgent dental condition.

Emergency care

Call 911 if you need an ambulance or go to the emergency room when you think you are in danger. An emergency 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, 7 days a week without preapproval. You don't need a referral.

Physical emergencies

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

- Broken bones.
- Bleeding that does not stop.
- Possible heart attack.
- Loss of consciousness.

- Seizure.
- Severe pain.
- Difficulty breathing.
- Allergic reactions.

More information about emergency care:

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

See a list of hospitals with emergency rooms on page 91.

Dental emergencies

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

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

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 800-431-4135. 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 on page 91.

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. PacificSource Community Solutions 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, and 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, 7 days a week.

Columbia Gorge:
Hood River County
Mid-Columbia Center for Living
1610 Woods Ct.,
Hood River, OR 97031
Call 24-hours a day, 7 days a week. Or call 911. 541-386-2620 Local
8:30 a.m. – 5:00 p.m., Monday – Friday

Crisis:
Crisis Team: 888-877-9147
Crisis Text Line: text “home” to 741741
Oregon Youth Line: 877-968-8491

Wasco County
Mid-Columbia Center for Living
1060 Webber St.
The Dalles, OR 97058
541-296-5452 Local
8:30 a.m. – 5:00 p.m., Monday – Friday

Crisis:
Crisis Team: 888-877-9147
Crisis Text Line: text “home” to 741741
Oregon Youth Line: 877-968-8491

Portland Crisis:
Multnomah County Crisis: 800-716-9769
Clackamas County Crisis: 503-655-8585
Washington County Crisis: 503-291-9111
Clark County Crisis: 800-686-8137

PacificSource Community Solutions' Customer Service: 800-431-4135 (TTY: 711). We accept all relay calls.
Hours: Monday through Friday, 8:00 a.m. to 5:00 p.m.
Learn about behavioral health benefits on page 59.

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

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

IMPORTANT!

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

Ask your doctor, counselor, therapist, or other treatment professional to assist you in making a plan for support during times of crisis. This plan will help you avoid access support during a crisis event and know how to get assistance when you need it.

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 PacificSource Community Solutions 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 below)
- Crisis respite (short-term care)
- Short-term places to stay to get stable
- Post stabilization services and urgent care services. This care is available 24 hours a day and 7 days a week. Post Stabilization care services are covered services, related to a medical or behavioral health emergency, that are provided after the emergency is stabilized and to maintain stabilization or resolve the condition.

- Crisis response services, 24 hours a day, for members receiving intensive in-home behavioral health treatment.

See more information about behavioral health services that PacificSource Community Solutions offers on page 59.

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:

- Dialing 988 for a mental health clinician response.
- Dialing 911 if you or someone else is in immediate danger.
- Searching for your county mental health crisis number online. They can provide screenings and help you get the services you need. For a list of additional crisis hotlines, see page 94, or go to https://www.mccfl.org/services/mental-health/crisis/.

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 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

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

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

To learn more about how you may be able to get a prescription refill before your trip, see page 91.

Emergency care away from home

You may need emergency care when away from home or outside of the PacificSource Community Solutions' 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, PacificSource Community Solutions is not allowed to pay you back. See page 100 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 PacificSource Community Solutions' ID card with you when you travel out of state.

2. Show them your PacificSource Community Solutions ID Card and ask them to bill PacificSource Community Solutions.

3. Do not sign any paperwork until you know the provider will bill PacificSource Community Solutions. Sometimes PacificSource Community Solutions cannot pay your

bill if an agreement to pay form has been signed. To learn more about this form, see page 101.

4. You can ask that the Emergency Room or provider's billing office to contact PacificSource Community Solutions 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 PacificSource Community Solutions 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 from being billed for services that PacificSource Community Solutions can cover. PacificSource Community Solutions 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 PacificSource Community Solutions. 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.

PacificSource Community Solutions pays for all covered services in accordance with the Prioritized List of Health Services, and the services must be medically or orally appropriate.

No PacificSource Community Solutions' in-network provider (for a list of in-network providers, see page 28) 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 PacificSource Community Solutions 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 PacificSource Community Solutions 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 at 800-431-4135 (TTY: 711). For more information about surprise billing, go to https://dfr.oregon.gov/Documents/Surprise-billing-consumers.pdf.

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

Call PacificSource Community Solutions for help right away at 800-431-4135 (TTY: 711).

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 PacificSource Community Solutions, 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 PacificSource Community Solutions 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 PacificSource Community Solutions, another insurance or gave a name that did not match the one on the PacificSource Community Solutions ID at the time of or after the service was provided, so the provider could not bill PacificSource Community Solutions. Providers must verify your PacificSource Community Solutions 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/or 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 PacificSource Community Solutions you may have to pay for your services. Before you see a provider that is not in-network with PacificSource Community Solutions, 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 page 28.

- **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 PacificSource Community Solutions. 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 PacificSource Community Solutions' Customer Service first to discuss what is covered. If you get a bill, please contact PacificSource Community Solutions' 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 PacificSource Community Solutions' Customer Service at 800-431-4135 (TTY: 711).

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 PacificSource Community Solutions or OHP. The form is also called a waiver. You can see a copy of the form at https://bit.ly/OHPwaiver.

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

- The form must have the estimated cost of the service. This must be the same as on the bill.
- The service is scheduled within 30 days from the date you signed the form.
- The form says that OHP does not cover the service.

- The form says you agree to pay the bill yourself.
- You asked to privately pay for a covered service. If you choose to do this, the provider may bill you if they tell you in advance the following:
    - The service is covered and PacificSource Community Solutions would pay them in full for the covered service.
    - The estimated cost, including all related charges, the amount PacificSource Community Solutions would pay for the service. The provider cannot bill you for an amount more than PacificSource Community Solutions would pay; and,
    - You knowingly and voluntarily agree to pay for the covered service.
- The provider documents in writing, signed by you or your representative, that they gave you the information above, and:
    - They gave you a chance to ask questions, get more information, and consult with your caseworker or representative.
    - You agree to privately pay. You or your representative sign the agreement that has all the private pay information.
    - The provider must give you a copy of the signed agreement. The provider cannot submit a claim to PacificSource Community Solutions 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 PacificSource Community Solutions' 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 PacificSource Community Solutions' Customer Service as soon as possible at 800-431-4135 (TTY: 711).
  Hours:

  October 1 to January 31:

  We are open 7 days a week from 8:00 a.m. to 8:00 p.m.

  February 1 to September 30:

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

We are closed on the following holidays:

- New Year's Day
- Memorial Day
- 4th of July
- Labor Day
- Thanksgiving Day and the day following
- Christmas Day

- 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 PacificSource Community Solutions, contact Customer Service. Learn more about denials, your right to an appeal, and what to do if you disagree with us, on page 115.
    - You can also appeal by sending PacificSource Community Solutions 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 PacificSource Community Solutions.

- PacificSource Community Solutions pays for all covered services in accordance with the Prioritized List of Health Services, see page 35.

- For a brief list of benefits and services that are covered under your OHP benefits with PacificSource Community Solutions, who also covers case management and care coordination, see page 35. If you have any questions about what is covered, you can ask your PCP or call PacificSource Community Solutions' Customer service.

- No PacificSource Community Solutions' 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 PacificSource Community Solutions for services you are not responsible for.

- Members are never charged for rides to covered appointments. See page 83. 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 PacificSource Community Solutions 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 page 115.

- In the event of PacificSource Community Solutions closing, you are not responsible to pay for services we cover or provide.

Members with OHP and Medicare

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

If you have both, you are not responsible for:

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

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

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

Call Customer 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 PacificSource Community Solutions. PacificSource Community Solutions 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 PacificSource Community Solutions. If they still say you owe money, call Customer Service at 800-431-4135, (TTY: 711). We can help you.
- Learn about the few times a provider can send you a bill on page 100.

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 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; or
- 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; or
- 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, or
    - You asked for a certain plan and the state put you in a different one.
- In the first 90 days after you join OHP or
    - 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: PacificSource Community Solutions wants to make sure you receive the best possible care. PacificSource Community Solutions 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 PacificSource Community Solutions.

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) from Monday through Friday, 8 a.m. to 5 p.m. PT. Use your online account at ONE.Oregon.gov or email OHP at Oregon.Benefits@odhsoha.oregon.gov .

You can get care while you change your CCO. See page 108 to learn more.

PacificSource Community Solutions can ask you to leave for some reasons

PacificSource Community Solutions 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 PacificSource Community Solutions' staff. When the act or threat of violence seriously impairs PacificSource Community Solutions' 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 page 115 for how to make a complaint or ask for an appeal.

PacificSource Community Solutions 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 PacificSource Community Solutions disagrees with.

For more information or questions about other reasons you may be disenrolled, temporary enrollment exceptions or enrollment exemptions, call PacificSource Community Solutions at 800-431-4135 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 as 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 PacificSource Community Solutions, 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 PacificSource Community Solutions' Customer Service at 800-431-4135 (TTY: 711). Hours: Monday through Friday, 8:00 a.m. to 5:00 p.m. PST.

PacificSource Community Solutions 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 PacificSource Community Solutions' network until one of these happen:
    - The minimum or approved prescribed treatment course is completed, or
    - Your provider decides your treatment is no longer needed. If the care is by a specialist, the treatment plan will be reviewed by a qualified provider.
- Some types of care will continue until complete with the current provider. These types of care are:

- Care before and after you are pregnant/deliver a baby (prenatal and postpartum).
- Transplant services until the first year post-transplant.
- Radiation or chemotherapy (cancer treatment) for their course of treatment.
- Medications with a defined least course of treatment that is more than the transition of care timeframes above.

You can get a copy of the PacificSource Community Solutions' Transition of Care Policy by calling Customer Service at 800-431-4135. It is also on our website on the Documents and Forms page at https://pacificsource.com/medicaid/your-plan/member-documents-and-forms. 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**.

To access our policies and procedures on advance directives, please visit https://pacificsource.com/sites/default/files/2022-12/Advance%20Directives%20Policies%20and%20Procedures.pdf.

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.
- 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 booklet on advance directives. It is called "Making Health Care Decisions". Just call us to learn more, get a copy of the booklet and the Advance Directive form. Call PacificSource Community Solutions' Customer Service at 800-431-4135.

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: https://www.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 PacificSource Community Solutions 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.
- PacificSource Community Solutions will honor any choices you have listed in your completed and signed Advance Directive.

If a PacificSource contracted health care provider cannot implement an Advance Directive as a matter of conscience (something that people must decide about according to what they believe is morally right), the provider will issue a clear and precise written statement. The statement will include:

- Explanation of the differences between institution-wide objections based on conscience and those that may be raised by individual physicians;
- Identification of the State legal authority permitting such objection; and description of the range of medical conditions or procedures affected by the conscience objection.

If a health care provider is unable or not willing to carry out an advance directive, the following will apply:

- The health care provider will tell the health care representative if the patient is incapacitated (unable to care for themself or their affairs).
- If the authority or decision of the health care representative is in question, the health care representative or health care provider may look to the courts for guidance. They can do this by filing a petition with the courts as outlined in ORS 127.550 (Petition for Judicial Review of Advance Directives).
- If there isn't a health care representative for the incapacitated patient, and the health care decisions are not in dispute, the health care representative will make a reasonable effort to locate a different doctor or health care provider and authorize the transfer of the patient to that doctor or health care provider.

How to complain if PacificSource Community Solutions 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 users, please call 711)
Hours: Monday through Friday, 8 a.m. to 5 p.m. PT
Mail a complaint to:
1430 Tandem Ave NE, Suite 180
Salem, OR 97301
Email: hlo.info@odhsoha.oregon.gov

Call PacificSource Community Solutions' Customer Service at 800-431-4135 (TTY: 711) to get a paper copy of the complaint form.

You can find complaint forms and learn more at:
https://www.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 information, contact Oregon Health Decisions at 800-422-4805 or 503-692-0894 (TTY 711).

What is the difference between a POLST and advance directive?

Portable Orders for Life-Sustaining Treatment (POLST)

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

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

To learn more, visit: https://oregonpolst.org.

Email: polst@ohsu.edu or call Oregon POLST at 503-494-3965.

Declaration for Mental Health Treatment

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

What does this form do for me?

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

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

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

To learn more about the Declaration for Mental Health Treatment, visit the State of Oregon's website at https://aix-xweb1p.state.or.us/es_xweb/DHSforms/Served/le9550.pdf

If your provider does not follow your wishes in your form, you can complain. A form for this is at http://www.healthoregon.org/hcrqi. 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 healthcare dollars are spent helping our members be healthy and well. We need your help to do that.

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

Medicaid Fraud is against the law and PacificSource Community Solutions takes this seriously.

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

- A provider charging you for a service covered by PacificSource Community Solutions
- 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

PacificSource Community Solutions 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 on-line or write directly to PacificSource Community Solutions. **We report all suspected fraud, waste, and abuse committed by providers or members to the state agencies listed below.**

Call PacificSource Community Solutions' Customer Service: 800-431-4135, TTY:711 or anonymously report using our EthicsPoint hotline number at 888-265-4068 or online at https://secure.ethicspoint.com/domain/media/en/gui/16499/index.html.
Fax: 541-322-6424
Submit a report by email: CS@PacificSource.com.
Write to**:**
Pacific Source Community Solutions
ATTN: Customer Service
PO Box 5729
Bend, Oregon 97708

OR

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

DHS Fraud Investigation Unit
P.O. Box 14150
Salem, OR 97309
Hotline: 1-888-FRAUD01 (888-372-8301)
Fax: 503-373-1525 Attn: Hotline
Website: https://www.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: 1-888-FRAUD01 (888-372-8301)
Fax: 503-378-2577
Website: https://www.oregon.gov/oha/FOD/PIAU/Pages/Report-Fraud.aspx
Secure email: OPI.Referrals@oha.oregon.gov

OR

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

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

Complaints, Grievances, Appeals and Fair Hearings

PacificSource Community Solutions 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:

PacificSource Community Solutions

Attn: Appeals and Grievances

PO Box 5729

Bend, OR 97708

Phone: 800-431-4135 (TTY: 711)

You can make a complaint

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

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

You have a right to make a complaint if you are not satisfied with any part of your care. We will try to make things better. Just call Customer Service at 800-431-4135 (TTY: 711). We accept all relay calls. For information on certified Health Care Interpreters, call 800-431-4135 (TTY: 711). You can also make a complaint with OHA or Ombuds. You can reach OHA at 1-800-273-0557 or Ombuds at 1-877-642-0450.

or

Write:

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

You may also find a complaint form at https://pacificsource.com/medicaid/your-plan/member-documents-and-forms.

You can file a complaint about any matter other than a denial for service or benefits and at any time orally or in writing. If you file a complaint with OHA, it will be forwarded to PacificSource Community Solutions.

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 PacificSource Community Solutions
- Care you were not sure about, but got anyway
- Bills for services you did not agree to pay

- Disputes on PacificSource Community Solutions' extension proposals to make approval decisions
- Driver or vehicle safety
- Quality of the service you received

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

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

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

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

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

PacificSource Community Solutions, 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.

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 800-431-4135 (TTY: 711) or use the Request to Review a Health Care Decision form. The form will be sent with the denial letter. You can also get it at https://bit.ly/request2review.

	You can mail the form or written request to: PacificSource Community Solutions Attn: Appeals and Grievances P.O. Box 5729 Bend, OR 97708 You can also fax the form or written request to 541-322-6424. **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 https://bit.ly/request2review. Ask for a fast appeal if waiting for the regular appeal could put your life, health or ability to function in danger. We will call you and send you a letter, within 1 business day, to let you know we have received your request for a fast appeal. **How long does a fast appeal take?** If you get a fast appeal, we will make our decision as quickly as your health requires, no more than 72 hours from when the fast appeal request was received. We will do our best to reach you and your provider by phone to let you know our decision. You will also get a letter. At your request or if we need more time, we may extend the timeframe for up to 14 days. If a fast appeal is denied or more time is needed, we will call you and you will receive written notice within two days. A denied fast appeal request will become a standard appeal and needs to be resolved in 16 days or possibly be extended 14 more days.

	If you don't agree with a decision to extend the appeal timeframe 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 https://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 https://bit.ly/request2review. You can send the form to: OHA Medical Hearings 500 Summer St NE E49 Salem, OR 97301 Fax: 503-945-6035 The state will decide if you can have a fast hearing 2 working days after getting your request. **Who can ask for a hearing?** You or someone with written permission to speak for you. That could be your doctor or an authorized representative. **What happens at a hearing?** At the hearing, you can tell the Oregon Administrative Law judge why you do not agree with our decision about your appeal. The judge will make the final decision.

Questions and answers about appeals and hearings

What if I don't get a denial letter? Can I still ask for an appeal?
You have to get a denial letter before you can ask for an appeal.

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

What if PacificSource Community Solutions 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 was sent with the denial letter (NOABD). Get the form at https://bit.ly/request2review.

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

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

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

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 800-431-4135 (TTY: 711) or use the Request to Review a Health Care Decision form. The form will be sent with the denial letter. You can also get it at https://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:
PacificSource Community Solutions
Attn: Appeals and Grievances
P.O. Box 5729
Bend, OR 97708

You can also fax the form or written request to 541-322-6424.

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 PacificSource Community Solutions and Medicare, you may have more appeal rights than those listed above. Call Customer Service at 800-431-4135 (TTY: 711) for more information. You can also call Medicare at 541-382-5920 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 PacificSource Community Solutions at 800-431-4135 (TTY: 711) to ask for free copies of all paperwork used to make the decision.

Words to Know

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

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

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

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

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

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

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

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

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

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

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

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

Declaration of Mental Health Treatment – A form you can fill out when you have a mental health crisis and can't make decisions about your care. It outlines choices about

the care you want and do not want. It also lets you name an adult who can make decisions about your care.

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

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

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

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

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

Emergency dental condition - Immediate care needed to treat serious tooth and gum problems or injuries. Some examples include severe tooth pain, unusual swelling, an avulsed tooth, and bleeding that will not stop.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Physician services – Services that you get from a doctor.

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

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

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

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

Premium – The cost of insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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