PacificSource Community Solutions Coordinated Care Organization (CCO)

Your Oregon Health Plan Coverage

Marion & Polk

For members who live in Marion and Polk counties.

Updated January 1, 2025

PacificSource Community Solutions

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Help us improve this handbook

OHP wants to hear from you! We want to make sure you have the information you need. Your feedback can help PacificSource Community Solutions and OHP improve member handbooks.

Take the handbook survey! Scan the QR code or go to www.surveymonkey.com/r/tellOHP to answer a few questions.

SCAN FOR SURVEY

Handbook Updates

New and returning members are mailed a handbook when they join PacificSource Community Solutions. You can find the most up-to-date handbook here: 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:

We will send you a health survey to help PacificSource Community Solutions know what support you need. We will ask about your physical, behavioral, dental, and social health care needs. To learn more about this survey, go to the "Survey about your health" section.

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 "Your Benefits" section.

    - Primary Care Providers. Go to the “Primary Care Providers (PCP)” section.
    - Prior Approvals and Referrals. Go to the “Getting preapproval” section.
    - Rights and Responsibilities. Go to the “Rights and Responsibilities" section.
    - Rides to Care. Go to the “Free rides to care” section.
    - Care Coordination. Go to the “Get help organizing your care with Care Coordination” section.
    - Prescriptions. Go to the “Prescription medications” section.
    - Emergency Care. Go to the “Emergency care” section.
    - How long it takes to get care. Go to the “How long it takes to get care” section.
    - Grievances, Complaints and Appeals. Go to the “Complaints, Grievances, Appeals and Fair Hearings” section.

- 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
- Written materials in other languages
- Braille
- Large print
- Audio and other formats

You can 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.

PacificSource Community Solutions can email you materials.

You can ask by emailing us at CommunitySolutionsCS@PacificSource.com, or signing in to chat with us electronically at InTouch.PacificSource.com/Members/Account/SignIn. 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.

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/EI.

If you need help, please call us at 800-431-4135 (TTY: 711) or call OHP Client Services at 800-273-0557 (TTY: 711).

If you do not get the interpreter help you need from PacificSource Community Solutions, 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 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 711. Waa aqbalnaa wicitaanada gudbinta.

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

Simplified Chinese

您可获取本文件的其他语言版、大字版、盲文版或您偏好的格式版本。您还可要求提供口译员服务。**本帮助免**费。致电 800-431-4135 **或** TTY 711。**我**们会接听所有的转接来电。

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您可以从经过认证且合格的医疗口语翻译人员那里获得帮助。

Traditional Chinese

您可獲得本信息函的其他語言版本、大字版、盲文版或您偏好的格式。您也可申請口譯員。以上協助均為免費。請致電 800-431-4135 或聽障專線 TTY 711。我們接受所有傳譯電話。

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您可透過經認證的合格醫療保健口譯員取得協助。

Korean

이문서은 다른 언어, 큰 활자, 점자 또는 선호하는 형식으로 받아보실 수 있습니다. 통역사를 요청하실 수도 있습니다. 무료 지원해 드립니다. 800-431-4135 또는 TTY 711 에 전화하십시오. 저희는 중계 전화를 받습니다.

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

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.

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

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.

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Ви можете отримати допомогу від сертифікованого та кваліфікованого медичного перекладача.

Farsi

می‌توانید این نامه را به زبان‌های دیگر، درشت‌خط، بریل یا قالب ترجیحی دیگری دریافت کنید. می‌توانید مترجم شفاهی نیز درخواست کنید. این کمک رایگان است. با 800-431-4135 یا TTY 711 تماس بگیرید. تماس‌های رله را می‌پذیریم.

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می‌توانید از یک مترجم شفاهی دارای گواهی و باکفایت در زمینه بهداشت و

Swahili

Unaweza kupata herufi hii kwa lugha zingine, kwa herufi kubwa, kwa lugha ya maandishi kwa vipofu au namna yeyote unayopendelea. Unaweza pia kuomba mkalimani. Msaada huu ni wa bure. Piga 800-431-4135 au TTY 711. Tunakubali simu za kupitisha ujumbe.

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Unaweza pata usaidizi kutoka kwa mkalimani wa huduma ya afya aliyeidhinishwa na aliyehitimu.

Burmese

ဤစာကို အျခားဘာသာစကားမ်ား၊ ပုံႏွိပ္စာလုံးၾကီး၊ မ်က္ျမင္မ်ားအတြက္ ဘေရးလ္ သို႔မဟုတ္ သင္ပိုမိုႏွစ္သက္သည့္ ပုံစံျဖင့္ ရယူနိုင္ပါသည္။ သင္သည္ စကားျပန္တစ္ဦးလည္း ေတာင္းဆိုနိုင္ပါသည္။ ဤအကူအညီသည္ အခမဲ့ျဖစ္ပါသည္။ 800-431-4135 သို႔မဟုတ္ TTY 711 ကို ဖုန္းဆက္ပါ။ ထပ္ဆင့္ေခၚဆိုမႈမ်ားကို ကၽြန္ုပ္တို႔ လက္ခံပါသည္။

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သင့်သည့် သင်တန်းဆင်းလက်မှတ်ရှိုးငှ့် အရည်အချင်းရှိသည့် က်နှးမာေရး ေစာင့်ေရှာက်မှ၊ စကားျပန်ထိမ့ွလည်း အကူအညီရယူနိုင်ပါသည်။

Amharic

ይህንን ደብዳቤ በሌሎች ቋንቋዎች፣ በትልቅ ህትመት፣ በብሬይል ወይም እርሶ በሚመርጡት መልኩ ማግኘት ይችላሉ። በተጨማሪም አስተርጓሚ መጠየቅም ይችላሉ። ይህ ድጋፍ የሚሰጠው በነጻ ነው። ወደ 800-431-4135 ወይም TTY 711 ይደውሉ። የሪሌይ ጥሪዎችን እንቀበላለን።

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ፍቃድ ካለው እና ብቃት ካለው የጤና እንክብካቤ አስተርጓሚ ድጋፍ ማግኘት ይችላሉ።

Romanian

Puteți obține această scrisoare în alte limbi, cu scris cu litere majuscule, în Braille sau într-un format preferat. De asemenea, puteți solicita un interpret. Aceste servicii de asistență sunt gratuite. Sunați la 800-431-4135 sau TTY 711. Acceptăm apeluri adaptate persoanelor surdomute.

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Puteți obține ajutor din partea unui interpret de îngrijire medicală certificat și calificat.

Our nondiscrimination policy

Discrimination is against the law. 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
- National origin, primary language, and proficiency of English language
- Race
- Religion
- Color
- Sex, sex characteristics, sexual orientation, gender identity, or sex stereotypes
- Pregnant or related conditions
- Health status or need for services

If you feel you were treated unfairly for any of the above reasons, you can make a complaint. This is also called filing a grievance.

Make (or file) a complaint with PacificSource Community Solutions in any of these ways:

- Phone: Call our Section 1557 Coordinator at 800-431-4135 (TTY: 711)
- Fax: 541-322-6424
- Mail: PacificSource Community Solutions
  Attn: Appeals and Grievances
  PO Box 5729
  Bend, OR 97708
- Email: newappeal@pacificsource.com
- Web:

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

You can read our complaint process at https://pacificsource.com/medicaid/your-plan/complaints-and-appeals.

If you have a disability, PacificSource Community Solutions has these types of free help:

- Qualified sign language interpreters
- Written information in large print, audio, or other formats
- Other reasonable modifications

If you need language help, PacificSource Community Solutions has these types of free help:

- Qualified interpreters
- Written information in other languages

Need help filing a complaint? Need language help or reasonable modifications? Call Customer Service at 800-431-4135 or 541-330-2507, (toll-free at 888-970-2507) to

speak with a peer wellness specialist or personal health navigator. You also have a right to file a complaint with any of these organizations:

Oregon Health Authority (OHA) Civil Rights

- Phone: 844-882-7889, TTY 711
- Web: www.oregon.gov/OHA/EI
- 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/
- 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: OCRComplaint@hhs.gov
- Mail: Office for Civil Rights
  200 Independence Ave. SW, Room 509F, HHH Bldg.
  Washington, DC 20201

We keep your information private

We only share your records with people who need to see them. This could be for treatment or for payment reasons. You can limit who sees your records. Tell us in writing if you don't want someone to see your records **or** if you want us to share your records with someone. You can ask us for a list of who we have shared your records with.

If you want us to share your records and information with someone, please complete the Authorization to Use and Disclose Protected Health Information form. Visit https://pacificsource.com/medicaid/your-plan/member-documents-and-forms to find the form.

Please send it to:
PacificSource Community Solutions
PO Box 5729
Bend, OR 97708

If you want to prevent someone from seeing your records, please use the Request to Restrict Access to My Health Information form. Visit

https://pacificsource.com/medicaid/your-plan/member-documents-and-forms to find the form or email CommunitySolutionsCS@pacificsource.com.

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

You may be charged a reasonable amount for a copy of the requested records.

There may be times when the law restricts your access.
Psychotherapy notes and records prepared for court cases cannot be shared.

Providers may also not share records when, in their professional judgement, sharing records could cause substantial harm to you or another person.

If a provider denies you or your authorized representative copies of your medical records, the provider must give you a written notice. The notice must explain why the request was denied and explain your rights to have another provider review the denial. The notice will also tell you how to make a complaint to the provider or the Secretary of Health and Human Services.

What's in this handbook

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, social, and behavioral health care services. OHP will also help with prescriptions and rides to care.

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

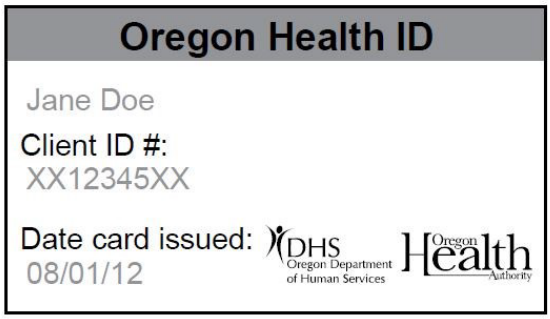
We work with other organizations to help manage some of your benefits, like dental services and rides to care. For a full list of these organizations and services, please see the "Contact Us" section.

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). When you ask for this information, we will send it within 5 business days.

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 in the "Your benefits" and "Extra Services" sections.

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 CCO plan

covers. Use your ID card and the table below to see what type of care is covered for you.

CCO or OHA: Who organizes and pays for your care?			
Coverage type	**Physical health**	**Dental health**	**Behavioral health**
CCO-A	PacificSource Community Solutions	PacificSource Community Solutions	PacificSource Community Solutions
CCO-B	PacificSource Community Solutions	OHA	PacificSource Community Solutions
CCO-E	OHA	OHA	PacificSource Community Solutions
CCO-F* (COFA and Veterans)	Not covered	PacificSource Community Solutions	Not covered
CCO-F* (members with full OHP benefits)	OHA	PacificSource Community Solutions	OHA
CCO-G	OHA	PacificSource Community Solutions	PacificSource Community Solutions
Open card**	OHA	OHA	OHA

*CCO-F includes OHA members who have their dental benefit administered by a CCO and their other OHA benefits administered through the OHA (also called open card). Some CCO-F members such as COFA and Veterans members have only dental benefits and no other OHP benefits.
**Open card is also called fee-for-service.

Learn more about organizing your care in the “Care Coordination” section or see what type of benefits are covered in the “Your Benefits” section.

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 (01/01/25), Memorial Day (05/26/25), Independence Day (07/04/25), Labor Day (09/01/25), Thanksgiving (11/27/25), Friday after Thanksgiving (11/28/25), and Christmas (12/25/25).

If PacificSource Community Solutions has an emergency office closure, we will update our operating hours on social media and post signs on public access doors. These signs and our social media updates will include phone numbers for assistance.

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 more in the "Physical Health benefits" section.

- Pharmacy benefits
  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 more in the "Prescription Medications" section.

- Behavioral health, drug, alcohol dependency, or substance use disorder treatment benefits and care
  Polk County
  Polk County Mental Health Department
  182 SW Academy Street, Suite 333
  Dallas, OR 97338
  503-623-9289 Local
  503-831-1726 Fax

  Polk County Mental Health Department
  1310 Main Street East
  Monmouth, OR 97361

503-400-3550 Local
503-837-0095 Fax

Polk County Adult Behavioral Health
1520 Plaza Street NW
Salem, OR 97304
503-585-3012 Local
503-585-0128 Fax

CRISIS:
503-623-9289 Weekdays 8:00 am – 5:00 pm (excluding holidays)
503-581-5535 or 800-560-5535 – Outside of regular business hours

Marion County
Marion County Adult Behavioral Health
2045 Silverton Rd., NE, Suite B
Salem, OR 97301
503-588-5351 Local
503-585-4908 Fax

Marion Adult Behavioral Health - Rural Services
976 N Pacific Highway
Woodburn, OR 97071
503-981-5851 Local
503-566-2977 Fax

Marion Psychiatric Crisis Center
1118 Oak St. SE
Salem, OR 97301
503-585-4949 Local
503-585-4965 Fax

MCHHS Children's Behavioral Health serves individuals ages 0 to 18. If you are experiencing a crisis, call our centralized intake line for help. You don't not need a referral to access our services. Anyone may reach out. We are here to help. Centralized Intake Line: 503-576-4676.

Marion County Children's Behavioral Health
3867 Wolverine St NE, Building F
Salem, OR 97305
503-588-5352 Local
503-585-4990 Fax

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 more in the “Behavioral health care benefits” section.

- 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.InterDent.com/CapitolDentalCare/

  ODS Community Dental Customer Service:
  800-342-0526 Toll-free
  TTY: 711
  http://ODSCommunityDental.com
  Learn more in the “Dental benefits” section.

- Vision benefits and care
  Customer Service at 800-431-4135 (TTY: 711. We accept all relay calls.)
  Fax: 541-322-6423
  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 more in the “Physical health benefits” section.

- 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 844-544-1397 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 in the “Free rides to care” section.

Contact the Oregon Health Plan

OHP Customer Service can help:

- Change address, phone number, household status or other case 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 an email to OHP.
    - For questions or changes about your OHP case, email Oregon.Benefits@odhsoha.oregon.gov.
    - For questions about CCOs or how to use your medical, email Ask.OHP@odhsoha.oregon.gov.
    - Tell OHP 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 in the “Complaints, Grievances, Appeals and Fair Hearings” section. 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. Minors 15 years and older can get medical and dental care without parental consent. To learn more, read “Minor Rights: Access and Consent to Health Care.” This booklet tells you the types of services minors of any gender 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 "Free help in other languages and formats" section)
- Materials, like this handbook, 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 "Health records" section). You can:
    - 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 "Primary Care Providers (PCPs)" section)
- 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 it will 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 “Getting care by video or phone” section)
- 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 ”Free help in other languages or formats” section). 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 “Your benefits” section)
- Urgent and emergency services 24 hours a day, 7 days a week without approval or permission. (See both “Urgent” and “Emergency” care sections)
- Referrals to specialty providers for covered coordinated services that are needed based on your health. (See “Provider referrals and self-referrals” section)
- Extra support from an OHP Ombudsperson. (See “Your Rights and Responsibilities” section above)

You have the right to do these things

- Choose your providers and to change those choices. (See “Primary Care Providers (PCP)” section)
- Get a second opinion. (See “Second opinion” section)
- 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 “Advance directives” section)

- Make a complaint or ask for an appeal. Get a response from PacificSource Community Solutions when you do this. (See “Complaints, Grievances, Appeals and Fair Hearings” section)
    - 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 “You can have an interpreter” section)

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 report this information to OHP

If you get OHP, you must report certain changes about you and your household. Your OHP approval letter tells you what you must report and when.

You can report changes in one of these ways:

- Use your ONE online account at One.Oregon.gov to report changes online.
- Visit any Oregon Department of Human Services Office in Oregon. You can find a list of offices at: https://www.oregon.gov/odhs/Pages/office-finder.aspx
- Contact a local OHP-certified community partner. You can find a community partner at: https://healthcare.oregon.gov/Pages/find-help.aspx
- Call OHP Customer Service weekdays at 800-699-9075.
- Fax to 503-378-5628
- Mail to ONE Customer Service Center, PO Box 14015, Salem, OR 97309.

There are other rights and responsibilities you have as an OHP member. OHP shared these when you applied. You can find a copy at https://www.oregon.gov/odhs/benefits/pages/default.aspx, under the "Rights and Responsibilities" link.

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 called Authorization to Use and Disclose Protected Health Information.
- 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 https://www.naranorthwest.org

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

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 in the “Changing CCOs and moving care” section.

If you want PacificSource Community Solutions to know you are an American Indian or Alaska Native, contact OHP Customer Service at 800-699-9075 (TTY 711) or login to your online account at ONE.Oregon.gov to report this.

You may be assigned a qualifying tribal status if any one of the following are true. These questions are also asked on the OHP application:

- You are an enrolled member of a Federally Recognized Tribe or a shareholder in an Alaska Native Regional Corporation.
- You get services from Indian Health Services, Tribal Health Clinics, or Urban Indian Clinics.
- You have a parent or grandparent who is an enrolled member of a Federally Recognized Tribe or a shareholder in an Alaska Native Regional Corporation or Village.

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:

- While you are waiting for an appointment, you can 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 the “Care Coordination” section to learn more)
    - If you are becoming a new Medicare enrollee, see the “Members with OHP and Medicare” section for more information.
- 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 (TTY: 711) if you have questions and want to learn about your benefits. They can help you with what you need.

Primary care providers (PCPs)

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

Primary care providers (PCPs) can be doctors, nurse practitioners and more. You have a right to choose a PCP within the 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 at 800-431-4135 (TTY: 711) 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.

To find a Mental Health Provider who is currently accepting new members, please review our Provider Directory or contact our Customer Service Department at 800-431-4135 (TTY: 711) for assistance.

To locate a Pharmacy, please refer to the Pharmacy Directory or contact our Customer Service Department at 800-431-4135 (TTY: 711) for assistance.

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 assign you to a primary care dentist (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 a dentist that will be their primary care dentist (PCD). You will go to your PCD for most of your dental care needs. Your PCD will send you to a specialist if you need to go to one. If you want to choose a different PCD, you can call your DCO for help choosing a PCD that best meets your needs. To change your assigned DCO, please call PacificSource. You can start seeing your new PCD on the first day of the following month after changes to assigned DCO are made.

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. You can start seeing your new PCP 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 "Changing CCOs or moving care" section)
- You are American Indian or Alaskan Native. (See "American Indian and Alaska Native Members" section)

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 of the directory. 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 in "Free rides to care" section.

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

Within 90 days of enrollment and if you have a health related change, PacificSource Community Solutions may send 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 call 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, dental health and medical history.
- Your primary language.
- Any special health care needs, such as high risk pregnancy, chronic conditions, behavioral health disorders, and disabilities, etc.
- If you want support from a care coordination team.

Your answers help us find out:

- If you need any health exams, including eye or dental exams.
- If you have routine or special health care needs.
- Your chronic conditions.
- If you need long-term care services and supports.
- Safety concerns.

- Difficulties you may have with getting care.
- If you need extra help with Care Coordination. See “Get help organizing your care with Care Coordination” section to learn more.

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, or sooner, if needed. 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 will be shared with your doctor or other providers to reduce how many times you are asked these questions. Sharing your survey also helps coordinate your care and services.

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. We will cover after pregnancy benefits for a full year, no matter how the pregnancy ends.

Here’s what you need to do when you find out you’re pregnant:

- ☐ **Tell OHP that you’re pregnant as soon as you know.** Call 800-699-9075 (TTY: 711) or login to your online account: 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.
- ☐ **Pregnancy Care Options.** You can receive care from a professional Birth Doula in your area at no cost. Search the Provider Directory online or call PacificSource Community Solution’s Customer Service toll-free at 800-431-4135 to get assistance with finding a Doula that can serve you in the language that works best for you. For more information, you can email your regional Traditional Health Worker Liaison at THWinfo@pacificsource.com.

After your pregnancy ends:

- ☐ **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.

Preventing Health Problems is Important

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

Some examples of preventive services:

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

A healthy mouth also keeps your heart and body heathier.

If you have any questions, please call us at 800-431-4135 (TTY: 711). We accept all relay calls.

Get help organizing your care with Care Coordination

PacificSource Community Solutions can help organize your care. PacificSource Community Solutions has staff that are part of your care coordination team. PacificSource Community Solutions' staff are committed to supporting members with their care needs and can assist you with finding physical, dental, behavioral and social health care where and when you need it.

You may get Care Coordination from your patient-centered primary care home (PCPCH), primary care provider, PacificSource Community Solutions, or other primary care teams. You, your providers, or someone speaking on your behalf can ask about Care Coordination for any reason, especially if you have a new care need or your needs are not being met. You can call the number below or visit

https://pacificsource.com/medicaid/get-care/member-support-specialists for more information about Care Coordination.

Care Coordination's goal is to make your overall health better.

PacificSource Community Solutions must have processes in place that help us find your health care needs. We will help you take charge of your health and wellness.

Your care coordination team will:

- Help you understand your benefits and how they work.
- Use care programs to help you manage chronic health conditions such as diabetes, heart disease and asthma.
- Help with behavioral health issues including depression and substance use disorder.
- Help with finding ways to get the right services and resources to make sure you feel comfortable, safe, and cared for.
- Help you identify people in your life or community that can be a support.
- 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:

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

Working together for your care

Your care coordination team will work closely with you. This team will have different people who will work together to meet your needs, like providers, specialists and community programs you work with. The team will connect you with community and

social support resources that may help you. 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 may need a care plan

You and your care team will decide if a care plan is needed. This plan will help meet your needs and is made with you, your care team and providers. 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, as your needs change, or if you ask for a review and update. You, your representative and your providers get a copy of your care plan.

You, an authorized representative or provider can request a copy of your care plan or request development of a Care Plan by contacting our Care Coordination team at 888-970-2507 (TTY: 711). We accept all relay calls.

Care Coordination hours and contact information

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

- Call PacificSource Community Solutions' Care Coordination team at 888-970-2507 (TTY: 711) if there is a change in your health, needs or who you are working with so PacificSource Community Solutions can help coordinate your care.
- Call PacificSource Community Solutions' Care Coordination team at 888-970-2507 (TTY: 711) to get more information about Care Coordination.
- PacificSource Community Solutions will send you a letter to let you know who, from your care coordination team, is primarily responsible for 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 “Comprehensive and preventive benefits for members under age 21” section 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 do not need a referral or preapproval for some services. This is called direct access. See the charts below for services that are direct access and do not need a referral or preapproval.

No referral or preapproval needed

- **Emergency services** (Available 24 hours a day, 7 days a week)
  For physical, dental, or behavioral health
- **Urgent Care services** (Available 24 hours a day, 7 days a week)
  For physical, dental, or behavioral health
- **Women's Health Services**
  For routine and preventive care
- **Sexual Abuse Exams**
- **Behavioral Health Assessment and Evaluation services**
- **Outpatient and Peer-Delivered Behavioral Health services**
  From an in-network provider

See the "Benefits Charts" section for more information.

Getting preapproval (sometimes called a "prior authorization")

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, and 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 for medical reasons.

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 (TTY: 711) if you:

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

You might not get the service if it is not approved. We review preapproval requests as quickly as your health condition requires. Most service decisions are made within 14 days. Sometimes a decision may take up to 28 days. This only happens when we are waiting for more information. If you or your provider feel following the standard time frame puts your life, health or ability to function in danger, we can make a faster decision called an "expedited service authorization". Expedited service decisions are typically made within 72 hours, but there may be a 14-day extension. You have the right to complain if you don't agree with an extension decision. See "Complaints, Grievances, Appeals and Fair Hearings" section 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 “Prescription medications” section to learn about prescriptions.

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

No preapproval is required for these services

- **Outpatient behavioral health services or peer delivered services** (in network)
- **Behavioral Health assessment and evaluation services**
- **Medication Assisted Treatment for Substance Use Disorder**
- **Assertive Community Treatment (ACT) and Wraparound services**

  (a screening in required by provider)

See the “Benefits Charts” section for more information.

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. To see an out-of-network provider, they must work with the Oregon Health Plan. 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

See the “Benefits Charts” section for more information.

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. See “Provider Directory” section to learn more.

Services you can self-refer to:

- Visits with your PCP
- Care for sexually transmitted infections (STIs)
- Immunizations (shots)
- Traditional health worker services
- Routine vision providers in the network
- Visits with your Primary Care Dentist (PCD)
- Family planning services (including out-of-network)
- Mental health services for problems with alcohol or other drugs
- Assertive Community Treatment
- Behavioral Health services (in network)

See the “Benefits Charts” section for more information.

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

For a summary of OHP benefits and coverage, please visit OHP.Oregon.gov/Benefits. You can get a paper or electronic copy of the summary by calling 800-273-0057.

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.

Service	How to access	Who can get it?
Care Coordination Services Care Coordination services can organize care activities, help you with chronic conditions, and bring together your care team. Example: Case management No limits to care. See "Get help organizing your care" section for more information.	 No referral or preapproval	All members

Service	How to access	Who can get it?
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 on a 12-month calendar year. 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
Comfort Care & Hospice Services End-of-life care like help managing symptoms and pain. Example: Hospice 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.	 Some services need to be approved in advance. Please call Customer Service to find out what services need approval in advance.	All members
Death with Dignity (assisted death for terminally ill) A physician-facilitated death. Covered by OHP	 Some services need to be approved in	All members

Service	How to access	Who can get it?
Services must be performed by an attending physical or consulting physician.	advance. Please call Customer Service to find out what services need approval in advance.	
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
Diagnostic Services Tests, exams or procedures to identify a condition or injury. Examples: Blood test or biopsy 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

Service	How to access	Who can get it?
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 • Office visits and treatment There are no limits on medically necessary drug and alcohol treatment benefits.	 No referral is required for drug and alcohol services. Some services may require approval. Contact Customer Service for details.	All members
Durable Medical Equipment (DME) and Supplies Supplies and equipment that don't wear out. Examples: Walkers or diabetic supplies 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

Service	How to access	Who can get it?
Early & Periodic Screening, Diagnosis and Treatment (EPSDT) services Care, screenings and assessments of physical and mental health development for members under 21. Example: Well care visits, and Lead toxicity screening. This includes coverage for all medically necessary and medically appropriate services for members under 21. All medically necessary and medically appropriate services for members age 20 and under, including screenings and assessments of physical and mental health development care covered.	 No referral or preapproval for well child care, screenings and some assessments. Referrals or preapproval may be required for other services.	Members ages 0-20 years old
Elective Surgeries/Procedures Surgeries and procedures that are not medically necessary or a result of an emergency. Example: Kidney stone removal These procedures are normally not covered. Any exception requires prior approval.	 Any exception requires prior approval.	All members
Emergency Medical Transportation Ride to hospital because of an emergency. Example: Ambulance ride. 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
Emergency Services		All members

Service	How to access	Who can get it?
Immediate medical care for an emergency. Example: Care when you have trouble breathing. We cover emergency care within the United States.	 No referral or preapproval	
Family Planning Services Care to help you plan the timing and number of children you have or do not have. Example: Birth control or 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 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:	 No referral or preapproval This means you have direct access to these services. Some services or procedures require 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.	All members

Service	How to access	Who can get it?
• 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. IMPORTANT! Hysterectomies are not covered as a part of family planning.		
Gender Affirming Care Care to help support and affirm gender identity. Example: Hormone therapy 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	All members

Service	How to access	Who can get it?
	members trying to access gender affirming care. Please contact Customer Service and request to be referred to the Gender Affirming Care Team.	
Hearing Services* These services include things to test hearing or help you hear better. Examples: Audiology or hearing aids Hearing Exam In a 12-month period, you are eligible for: 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. Children through age 20: If you meet prior authorization requirements, you	 No referral or preapproval for hearing exams.  Services must be approved in advance for hearing aids. Adults: If you meet prior authorization	All members

Service	How to access	Who can get it?
may be covered for one hearing aid for each ear every three years.	requirements, you may be covered for one hearing aid for each ear every five years.	
Home Health Services Care in your home, often during an illness or after an injury. Example: Physical therapy Unlimited when medically necessary.	 With in-network providers, does not need approval in advance.	All members
Immunizations and Travel Vaccines Shots and vaccines to help keep you healthy. Example: Flu vaccine In addition to routine vaccines, we cover travel and nonroutine vaccines recommended by the Advisory Committee on Immunization Practices (ACIP). 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 Care you get when you stay in the hospital. Example: Surgery Some services or items may be limited based on medical necessity, coverage and OHP guidelines. Covered services may include:	 Preapproval needed	All members

Service	How to access	Who can get it?
• 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 If your situation is related to an urgent or emergency visit, please see “Emergency services” above		
Interpreter Services Someone to help you in the spoken language or sign language of your choice. Unlimited.	 No referral or preapproval	All members
Laboratory Services, X-Rays, and other procedures These are tests your provider might use to check your health. Examples: Urine test or X-ray	 No referral or preapproval	All members

Service	How to access	Who can get it?
Maternity Services Care you get before, during, and after a pregnancy. Example: Prenatal visit Unlimited for prenatal care and labor and delivery.	 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
Outpatient Hospital Services Hospital care that you can get without staying overnight. Examples: Chemo, Radiation, or Pain Management Unlimited.	 No referral or preapproval when medically necessary	All members
Palliative Care Care for members with serious illnesses, which may include services such as care coordination, mental health services, social work services, spiritual care services, pain and symptom management and 24-hour clinical phone support. Unlimited when medically necessary.	 Referral needed	Members with a serious illness and a life-limiting prognosis.
Pharmaceutical Services (Prescription Medication) Drugs you need to take to help keep or make you healthy. Example: Blood pressure medication	Prescription needed	All members

Service	How to access	Who can get it?
Physical Therapy, Occupational Therapy, Speech Therapy Therapies focus on improving your ability to move your body or perform daily activities. Example: Exercises to improve balance after a fall. 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
Preventive Services Regular care and screenings to keep you and your family healthy. Some examples are: physical examinations, immunizations, screenings (cancer, etc.), diabetes prevention, nutritional counseling, tobacco cessation services, etc. Covered once every 12 months. Digital rectal exam covered once per year. Pap Tests: Once every 3–5 years unless you have had an abnormal	 You do not need a referral for this service.	All members

Service	How to access	Who can get it?
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.		
Primary Care Provider (PCP) Visits Visits with your doctor for checkups, screenings, and non-urgent care. Example: Annual exam Unlimited office visits. Some procedures/treatments must be approved in advance.	 No referral or preapproval	All members
Rides to care. Also called Non-Emergent Medical Transportation (NEMT) Services Free rides to care or other transportation help like bus passes and pay for mileage. This is a free service. Unlimited.	 No referral or preapproval	All members
Sexual Abuse Exams Exam after sexual abuse, can include gathering evidence and getting lab tests. Unlimited.	 No referral or preapproval	All members

Service	How to access	Who can get it?
Specialist Services Care from a provider who has special training to care for a certain part of the body or type of illness. Example: Cardiologist (heart specialist) Office visits are unlimited for a covered condition.	 Preapproval may be needed	All members For those with special health care needs or Long-Term Services and Supports (LTSS), call Customer Service to get access to specialists.
Surgical Procedures Care to physically treat, remove, or alter your body to keep or make you healthy. Example: Removing an inflamed appendix Proof of smoking cessation or nonsmoking status may be required prior to certain elective surgical procedures.	 Approval in advance is required.	All members
Telehealth Services Getting care by phone, video, or online. Examples: Virtual visits or email visits. Please contact your doctor's office or Customer Service for more information. Unlimited.	 No referral or preapproval	All members
Traditional Health Worker (THW) Services Getting care or services from someone with similar life experiences. They can help you get care to support your wellbeing. Example: Peer Support Specialist	 No referral or preapproval	All members
Urgent Care Services Care you get when your health need is more urgent than a regular		All members

Service	How to access	Who can get it?
appointment. Examples: Sprains and strains 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.	No referral or preapproval	
Women's Health Services (in addition to PCP) for routine and preventive care Care for women's special health needs. Examples: Pap test, breast exam, or well-woman visit For more information, see Preventive Services and Family Planning Services 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 below, eye exams and eyeglasses may be covered: • Aphakia • Pseudo Aphakia • Keratoconus • Congenital Cataracts	 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?
• Corneal Transplant **Members under 21*, pregnant adults, adults up to 12 months post-partum are covered for:** • Routine eye exams when needed • Medical eye exams when needed • Corrective lenses/accessories when needed	 No referral or preapproval	*Members under 21 and pregnant members As recommended for all others
Examples of medical eye conditions are aphakia, keratoconus, or after cataract surgery.		

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.

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. PacificSource Community Solutions will coordinate services for free if you need help.

Service	How to access	Who can get it?
Assertive Community Treatment A team-based approach to help people with severe mental illness live in the community. Example: Crisis intervention Services and length of treatment are adjusted to meet the needs of each individual member.	 No referral or preapproval.	Members age 18 and above

Service	How to access	Who can get it?
Wraparound Services Whole-person care that helps youth and their families reach their goals by putting them at the center of their care. Example: Support groups 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.	Children and youth that meet criteria
Behavioral Health Assessment and Evaluation Services Tests and exams to help learn about possible behavioral health conditions. Example: Psychiatric diagnostic test 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) Short-term or long-term stay for members to get behavioral health treatment. Example: Residential program 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.	Youth under age 21
Inpatient Substance Use Disorder Residential and Detox Services Short-term or long-term stay for members to get treatment. Example: Alcohol use treatment 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) Care using medicine, counseling and other therapies to help treat substance use. Example: Methadone Services and length of treatment are adjusted to meet the needs of each individual member.	 No referral or preapproval	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
Behavioral Health Specialist Services Care from a provider who has special training in certain behavioral health conditions. Example: Psychiatrist	 No referral or preapproval	All members

Service	How to access	Who can get it?
There are no limits on behavioral health benefits. Services and length of treatment are adjusted to meet the needs of each individual member.		
Substance Use Disorder (SUD) services Care to can help you overcome addiction and stay drug-free. Example: Detox counseling Preapproval may be required for out-of-area providers. Services and length of treatment are adjusted to meet the needs of each individual member.	 No referral or preapproval for in area providers.	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).

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.

Service	How to access	Who can get it
Emergency and Urgent Dental care Care for dental problems that need immediate attention. No limits. Examples: Extreme pain or infection, bleeding or swelling, injuries to teeth or gums. No limits.	 No referral or preapproval	All members
Oral Exams An oral exam is when the dentist does a check-up to look for any areas where additional care may be needed. This includes looking for cavities or gum disease. Pregnant members: Twice a year Members under 21: Twice a year* All other members: 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.	 Referral needed if not seeing your primary care dentist	All members

Service	How to access	Who can get it
Oral Cleanings Dental cleanings help with long-term oral health. When you go for your routine cleaning, the plaque, tartar, and bad bacteria are removed. This helps prevent cavities. Members under 21: 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 A treatment to help strengthen and protect teeth. Members under 21: Twice a year* High risk youth and adults: Up to four times per year* All other adults: Once a year*	 No referral or preapproval	All members
Oral X-rays X-rays create a picture of your teeth and bones. Your dentist uses this to help review your oral health. Routine X-rays are covered once a year; more are covered if dentally or medically appropriate. *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
Sealants Thin coatings painted on the back teeth (molars) that can prevent cavities (tooth decay) for many years. *Under Age 16. On Adult Back Teeth Once Every 5 Years Sealants are not covered for adults.	 No referral or preapproval	Members under age 16*
Fillings A filling is used to treat a small hole, or cavity, in a tooth. There are no limitations. Replacement of a tooth-colored filling for a tooth not seen while smiling is limited to once every 5 years.* 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	All members*
Partial or complete dentures Dentures replace missing teeth. There are two types of dentures: complete and partial dentures. Complete dentures are used when all the teeth are missing and partial dentures are used when some natural teeth are left. Partial: Once every 5 years Complete: Once every 10 years Your DCO may require authorization for dentures. Contact your DCO. *In accordance with EPSDT requirements, all medically necessary and medically appropriate dental services are available to members under	 Preapproval may be required. Contact your DCO for additional information.  Referral needed if not seeing your primary care dentist	All members

Service	How to access	Who can get it
age 21. This table may not list all available EPSDT services.		
Crowns A dental crown is a tooth-shaped cap that restores a decayed, broken, weak or worn-down tooth. Dentists also use crowns to cover implants or root canals. Crowns are not covered for all teeth. Some Upper and Lower Front Teeth. 4 Crowns Every 7 Years. * 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 under age 21*
Extractions Removing a tooth completely from its socket. No limit.	 Referral needed if not seeing your primary care dentist	All members
Root Canal Therapy A root canal is a dental procedure to repair and save your tooth when it's badly decayed, damaged, or infected, by removing the center of the tooth. All members: Coverage for front teeth and pre-molars Pregnant members: Additional coverage on first molars	 Preapproval needed for molars	All members

Service	How to access	Who can get it
Members under 21: Additional coverage on first and second molars (not third molars/wisdom teeth) 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.	 Referral needed if not seeing your primary care dentist	
Orthodontics Care to diagnose and treat teeth or jaws that do not align. Examples: For cleft lip and palate, or when speech, chewing and other functions are affected. It is required to have approval from your dentist and you cannot 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.	 Preapproval needed	Members under 21*

The table above is not a full list of services that need preapproval or referral.
If you have questions, please call Customer Service at 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 (NEMT) 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).

OHP Bridge for adults with higher incomes

OHP Bridge is a new benefit package that covers adults with higher incomes. OHP Bridge is free. People who can get OHP Bridge must:

- Be 19 to 64 years old;
- Have an income between 138 percent and 200 percent of the federal poverty level (FPL);
- Have an eligible citizenship or immigration status to qualify; and,
- Not have access to other affordable health insurance.

If you report a higher income when you renew your OHP, you may be moved to OHP Bridge. Learn more about OHP Bridge at https://www.oregon.gov/oha/hsd/ohp/pages/bridge.aspx.

OHP Bridge is almost the same as OHP Plus. There are a few things that OHP Bridge does not cover, including:

- Long-term services and supports (LTSS)
- Health related social needs (HRSN)

Health Related Social Needs

Health-Related Social Needs (HRSN) are social and economic needs that affect your ability to be healthy and feel well. These services help members who are facing major life changes. Get more information at: https://www.oregon.gov/OHA/HSD/Medicaid-Policy/Pages/HRSN.aspx

Please ask PacificSource Community Solutions to see what free HRSN benefits are available. HRSN benefits include:

- Housing Services: Help with rent and utilities, storage fees, home modifications and remediation services, and services to support you as a tenant.
- Climate Related Supports: Help to get health related air conditioners, heaters, air filtration devices, portable power supplies and mini-refrigerators.
- Nutrition Services: Help for people to have a healthy diet including nutrition education, funds to buy groceries, hot meals, or fruits and vegetables, or delivery of medically tailored meals for people with specific health conditions.

You may be able to get some or all of the HRSN benefits if you are an OHP Member, and one or more of the below:

- Homeless or you have an income that is 30% or less than the area median income, and do not have resources or support networks to prevent homelessness;
- Discharged from an Institution for Mental Disease in the last 12 months;
- Released from incarceration in the last 12 months;
- Currently, or was previously involved with the Oregon child welfare system;
- A Young Adult with Special Healthcare Needs; or
- An individual who transitioned to dual status with OHP and Medicare within the last nine months, or will be transitioning to dual status within the next three months.

You must also meet other criteria. For questions or to be screened, please contact PacificSource Community Solutions. PacificSource Community Solutions can help you to schedule appointments for HRSN benefits.

Please note that to be screened and to get HRSN benefits, your personal data may be collected and used for referrals. You can limit how your information is shared.

If approved, you can choose how you get HRSN benefits. HRSN benefits are free to you and you can opt out at any time. If you get HRSN benefits, your care coordination team will work with you to make sure your care plan is updated. See “Care Coordination” section to learn more about care plans.

If your HRSN benefits are denied, you will receive written notice and you have the right to an appeal if you don’t agree with the decision. For more information, see “Complaints, Grievances, Appeals and Fair Hearings” section.

Important Notes:

- Rides to care cannot to be used for HRSN services.
- OHP Bridge does not cover HRSN Services.

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 (open card) program. CCOs sometimes call these services “non-covered” benefits. There are two types of services OHP pays for directly:

1. Services where you get care coordination from 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.

Contact PacificSource Community Solutions for the following services:

- Planned Community Birth (PCB) services, include prenatal and postpartum care for people experiencing low risk pregnancy as determined by the OHA Health Systems Division. OHA is responsible for providing and paying for primary PCB services including at a minimum, for those members approved for PCBs, newborn initial assessment, newborn bloodspot screening test, including the screening kit, labor and delivery care, prenatal visits and postpartum care.
- Long term services and supports (LTSS) not paid by 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

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

Contact OHP 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
- Services provided to Healthier Oregon Program members
- 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 "Free rides to care" section for more information. Call 844-544-1397 (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. There may be some providers within our network that might have moral or religious objections. Please reach out to us at 800-431-4135 (TTY: 711) if you have questions about this. We can help you find a provider who can provide the service.

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. PacificSource Community Solutions will make sure that your care is coordinated to meet your access needs. See “Care Coordination” section to learn more. 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. If you need help with transportation to and from appointments, see “Free rides to care” section.

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 on the next page:

Area Types:

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

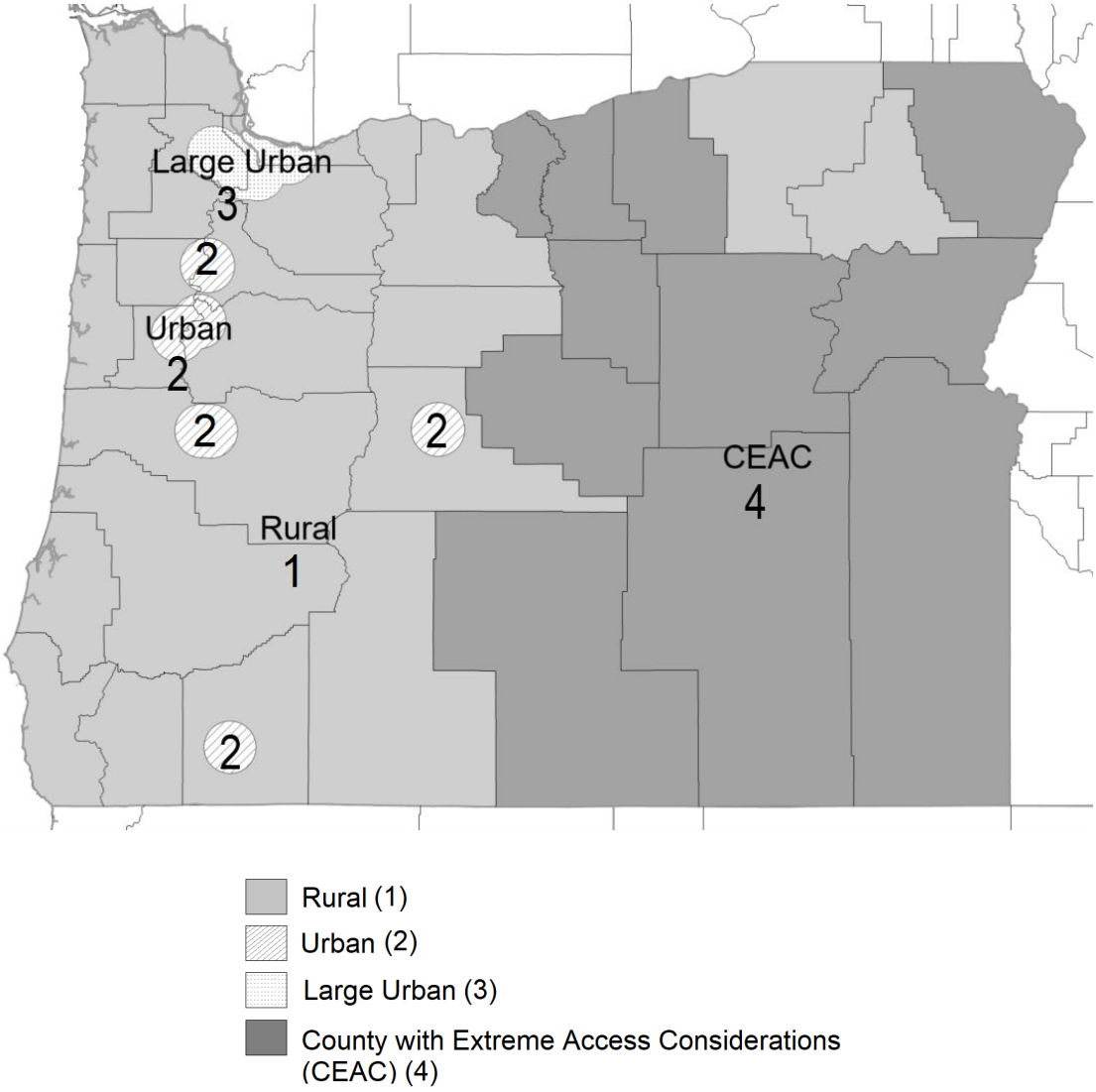


Figure 1: Map of geographic regions in Oregon as defined for network adequacy. Area distinctions include: Large Urban, Urban, Rural, and County with Extreme Access Considerations (CEAC).

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 program 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. Starting in 2025 Young Adults with Special Health Care Needs (ages 19 through 25) may also qualify for EPSDT benefits. Contact PacificSource Community Solutions for more information.

EPSDT 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.
- 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 “Your Benefits” section.

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 "Complaints, Grievances, Appeals and Fair Hearings" section.

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://www.aap.org/brightfutures. You can use the Well Visit Planner to prepare for these check-ups.

Your PCP will help you get these services and treatment when required by the guidelines.

Screening visits include:

- Developmental screening.
- Lead testing:
    - Children must have blood lead screening tests at age 12 months and 24 months. Any child between ages 24 and 72 months with no record of a previous blood lead screening test must get one.
    - Completion of a risk assessment questionnaire does not meet the lead screening requirement for children in OHP. All children with lead poisoning can get follow up case management services.
- Other needed laboratory tests (such as anemia test, sickle cell test, and others) based on age and risk.
- Assessment of nutritional status.
- Overall unclothed physical exam with an inspection of teeth and gums.
- Full health and development history (including review of both physical and mental health development).
- Immunizations (shots) that meet medical standards:
    - Child Immunization Schedule (birth to 18 years): https://www.cdc.gov/vaccines/hcp/imz-schedules/child-adolescent-age.html?CDC_AAref_Val=https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html
    - Adult Immunization Schedule (19+): https://www.cdc.gov/vaccines/hcp/imz-schedules/adult-age.html?CDC_AAref_Val=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 “Complaints, Grievances, Appeals and Fair Hearings” section.

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 (THW)

Traditional Health Workers (THW) provide support and 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 can also connect you with people and services in the community that can support 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 (CHW):** A community 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 (PHN):** 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 (PSS):** Someone who has life experiences with mental health and/or addiction and recovery. A PSS may also have been a support to a family member with mental health concerns and/or receiving addiction treatment. They give support, encouragement, and help to those facing addictions and mental health issues.

- **Peer Wellness Specialist (PWS):** 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.

THWs can help you with many things, like:

- Working with you and your care coordinator to find a new provider.
- Receiving the care you seek and need.
- Connecting you with others to explain your benefits.
- Providing information on mental health and/or addiction services and support.
- Information about and referrals to community resources you could use.
- Someone to talk to from your community.
- Going to provider appointments with you.

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

Call our 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 that are not regular OHP benefits. HRS help improve overall member and community health and well-being. HRS include flexible services for members and community benefit initiatives for members and the larger community. Because HRS are not regular OHP benefits, members do not have appeal rights for HRS the same way they do for covered services.

Flexible Services

Flexible services are support for items or services to help members stay healthy or become healthier. 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:

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

Learn more about health-related services at https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le4329.pdf.

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 to get help

requesting a flexible service. 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.

For a request to be eligible, it must align with Oregon Administrative Rule 410-141-3845.

Requested items and services must be:

- Cost effective
- Non-covered by Oregon Health Plan
- Designed to improve health quality
- Objectively improve health outcomes
- Based on evidence-based medicine or widely accepted best clinical practice
- Consistent with your treatment plan and supported by your provider.

If your flexible service request is denied, you will get a letter explaining your options. You can't appeal a denied flexible service, but you have the right to make a complaint. Learn more about appeals and complaints in the "Complaints, Grievances, Appeals and Fair Hearings" section.

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 funding for programs and for the larger community, including CCO members, 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 folks access fresh fruits and veggies through farmers markets
- Community-based programs that help folks get into or maintain safe and stable housing
- 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 Federally Qualified Health Centers (FQHC) and Rural Community Health Centers (RCHC). 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.

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 844-544-1397 (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 care.

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/medicaid/get-care/get-ride.

Schedule a ride

Call ModivCare at 844-544-1397 (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 call center staff who can help with rides 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 at 844-544-1397 (TTY: 711) when you know you need to cancel or reschedule your ride, at least 2 hours before the pick-up time.

You can call ModivCare 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

See "Complaints, grievances, appeals and hearings" section to learn more.

Rider's Guide

Get the Rider's 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 free paper copy. It will be sent in 5 business days. The paper copy can be in the language and format you prefer.

The guide has more information, like:

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

Getting care by video or phone

Telehealth (also known as telemedicine and teledentistry) is a way for you to get care without going into the clinic or office. Telehealth means you can have your appointment through a phone call or video call. 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 temporarily away from home and cannot meet with your doctor in person.
- If you are not sure if you need to go into the clinic or office.

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

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

Telehealth visits are private

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

Learn more about privacy and the Health Insurance Portability and Accountability Act (HIPAA) in the "We keep your information private" section.

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

You have a right to:

- Get telehealth services in the language you need.
- Have providers who respect your culture and language needs.

- Get qualified and certified interpretation services. Learn more in “You can have an interpreter” section.
- 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 its disaster plan.
- Get support and have the tools needed for telehealth.
    - PacificSource Community Solutions will help identify what telehealth tool is best for you.
- PacificSource Community Solutions will ensure your provider conducts an assessment to see if telehealth is right for you. This includes, but is not limited to:
    - Need for alternate format;
    - Access to necessary device(s);
    - Access to a private and safe location;
    - Access to internet service;
    - Understanding of digital devices;
    - Cultural concerns.

Talk to your provider about telehealth. If you need or prefer in person visits, and your provider is only a telehealth provider, let them know. They can refer you to another provider and tell PacificSource Community Solutions. You have a choice of how you receive your care and PacificSource Community Solutions can help coordinate care with another provider. 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 available network pharmacies in our Provider Directory under the Find a Pharmacy tab 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. 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 in "Members with OHP and Medicare" section.

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 hospital care. You can get emergency care at any hospital. Some hospitals offer a full emergency room to help someone experiencing a mental health crisis but you may go to any hospital for help.

Salem
Salem Health
Full emergency room: Yes
890 Oak St., SE Salem, OR 97301
503-561-5200 (TTY: 711), **800-876-1718 Toll-free**
https://www.SalemHealth.org

Silverton
Legacy Silverton Hospital
Full emergency room: Yes
342 Fairview St., Silverton, OR 97381
503-873-1500 (TTY: 711)
https://www.LegacyHealth.org/locations/hospitals/legacy- silverton-medical-center.aspx

Dallas
Salem Health West Valley
Full emergency room: Yes
525 SE Washington St., Dallas, OR 97338
503-623-8301 (TTY: 711)
https://www.SalemHealth.org/services/salem-health-west-valley

Stayton
Santiam Memorial Hospital
Full emergency room: Yes
1401 N. 10th Ave., Stayton, OR 97383
503-769-2175 (TTY: 711)
https://SantiamHospital.org

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 in "Urgent dental care" section.

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:

Marion County

Salem Health Urgent Care – Salem
1002 Bellevue St. SE, Salem, OR 97301
503-814-5554 (TTY: 711)
https://www.SalemHealth.org/services/primary- care/urgent-care

Salem Health Urgent Care – Woodburn
105 Arney Rd., Ste 130, Woodburn, OR 97071
503-902-3900 (TTY: 711)
https://www.SalemHealth.org/services/primary- care/urgent-care

Salem Clinic Urgent Care – Salem
2020 Capitol St. NE, Salem, OR 97301
503-364-9888 (TTY: 711)
https://SalemClinic.org/hours/urgent-care-centers

Salem Clinic Urgent Care – Salem
2531 Boone Rd. SE, Salem, OR 97306
503-485-8600 (TTY: 711)
https://SalemClinic.org/hours/urgent-care-centers

Salem Clinic Urgent Care – Keizer
5900 Inland Shores Way NE Keizer, OR 97303
503-589-6255 (TTY: 711)
https://SalemClinic.org/physicians/urgent care

Urgent Care Clinic South – Salem
3777 Commercial St. SE, Salem, OR 97302
503-588-1234 (TTY: 711)
https://www.UrgentCareSouth.com

Polk County:
Emurgent Care LLC – Dallas
109 E Ellendale Ave, Ste., B, Dallas, OR 97338
503-623-3199 (TTY: 711)
https://EmurgentCareMedical.com]

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 listed in "Important phone numbers" section. 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.
- Emergency care includes post stabilization (after care) services. After care services are covered services related to an emergency condition. These services are given to you after you are stabilized. They help to maintain your stabilized condition. They help to improve or fix your condition.

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

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 have a dental emergency and your dentist or PCP cannot help you, you don't need permission to get emergency dental care. You can go to the emergency room or call Customer Service at 800-431-4135 for help to find emergency dental care.

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

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, 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.

Polk County
Polk County Mental Health Department
182 SW Academy Street, Suite 333
Dallas, OR 97338
503-623-9289 Local
503-831-1726 Fax

Polk County Mental Health Department
1310 Main Street East
Monmouth, OR 97361
503-400-3550 Local
503-837-0095 Fax

Polk County Adult Behavioral Health
1520 Plaza Street NW
Salem, OR 97304
503-585-3012 Local
503-585-0128 Fax

CRISIS:
503-623-9289 Weekdays 8:00 am – 5:00 pm (excluding holidays)
503-581-5535 or 800-560-5535 – Outside of regular business hours

Marion County
Marion County Adult Behavioral Health
2045 Silverton Rd., NE, Suite B
Salem, OR 97301
503-588-5351 Local
503-585-4908 Fax

Marion Adult Behavioral Health - Rural Services

976 N Pacific Highway
Woodburn, OR 97071
503-981-5851 Local
503-566-2977 Fax

Marion Psychiatric Crisis Center
1118 Oak St. SE
Salem, OR 97301
503-585-4949 Local
503-585-4965 Fax

MCHHS Children's Behavioral Health serves individuals ages 0 to 18. If you are experiencing a crisis, call our centralized intake line for help. You don't need a referral to access our services. Anyone may reach out. We are here to help.
Centralized Intake Line: 503-576-4676.

Marion County Children's Behavioral Health
3867 Wolverine St NE, Building F
Salem, OR 97305
503-588-5352 Local
503-585-4990 Fax

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 in "Your benefits" section.

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

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 does 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
- Crisis respite (short-term care)
- Short-term places to stay to get stable
- Post stabilization services and urgent care services. This care is available 24 hours a day and 7 days a week. Post Stabilization care services are covered services, related to a medical or behavioral health emergency, that are provided after the emergency is stabilized and to maintain stabilization or resolve the condition.
- Crisis response services, 24 hours a day, for members receiving intensive in-home behavioral health treatment.

See more about behavioral health services offered in "Behavioral health care benefits" section.

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!

If you want to talk with someone outside of PacificSource Community Solutions, call any of the following:

- See list of crisis lines in “Behavioral health crisis and emergencies” section
- National Suicide Prevention Lifeline: Call 988 or visit https://988lifeline.org
- The David Romprey Memorial Warmline: 800-698-2392
- Crisis Text Line: Text 741741
- For teen suicide prevention: YouthLine: 877-968-8491 or text teen2teen to 839863

- You can also search 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 “Behavioral health crisis and emergencies” section, or go to the following websites:
    - Marion county: https://www.co.marion.or.us/HLT/MH/Pages/default.aspx.
    - Polk county: https://www.co.polk.or.us/bh/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 “Getting prescriptions before a trip” section.

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.

Do not pay for emergency care. If you pay the emergency room bill, PacificSource Community Solutions is not allowed to pay you back. See "Bills for services" section 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 "Bills for services" section.

4. You can ask that the Emergency Room or provider's billing office 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.

If you get a bill, see "If your provider sends you a bill, do not pay it" section below.

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, medically necessary and appropriate services in accordance with the Prioritized List of Health Services.

A PacificSource Community Solutions' in-network provider (for a list of in-network providers, see "In-network providers" section) or someone working for them cannot bill you or try to collect any money owed by PacificSource Community Solutions for services you are not responsible for covering.

Members cannot be billed for missed appointments or errors.

- Missed appointments are not billable to you 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, after PacificSource Community Solutions has paid, 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. You 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 service is not covered. If you choose 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 "In-network providers" section.

- **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 only be billed for a service if you sign the Agreement to Pay form. You should not feel forced to sign the form. You can see a copy of the form at https://bit.ly/OHPwaiver.

You do not have to sign the Agreement to Pay form if you do not want to. If you are unsure if you should sign the Agreement to Pay form or have any question about if a benefit is covered, please contact PacificSource Community Solutions Customer Services at 800-431-4135 (TTY: 711) for help. 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 "Complaints, Grievances, Appeals and Fair Hearings" section.

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. You should not be billed for emergency or post-hospitalization care. Contact PacificSource Community Solutions' Customer Service if you get a bill. We have resources to help. **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.
- 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, in "Complaints, Grievances, Appeals and Fair Hearings" section.
  - 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 “Your benefits” section.

- 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 “Your benefits” section. 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 “Free rides to care” section. 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 “Complaints, Grievances, Appeals and Fair Hearings” section.

- 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 in "Bills for Services" section.

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

Changing CCOs and moving care

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

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

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

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 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.

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 to a different 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 OHP Client Services 800-273-0557 (TTY 711) from Monday through Friday, 8 a.m. to 5 p.m. PT. You can use your online account at ONE.Oregon.gov or email OHP at Oregon.Benefits@odhsoha.oregon.gov.

The effective date of disenrollment will be the first of the month following OHA's approval of disenrollment.

You can get care while you change your CCO. See "Changing CCOs and moving care" section 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 threaten 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 "Complaints, Grievances, Appeals and Fair Hearings" section 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.
- Pre-transplant services and 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 doctor you work with has a moral objection to honoring your Advance Directive, please call PacificSource Community Solutions’ Customer Service at 800-431-4135 (TTY: 711) and request a new provider.

How to report 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
Online: https://www.oregon.gov/oha/PH/HLO/Pages/File-Complaint.aspx.

You can make a complaint to the Health Facility Licensing and Certification Program if a facility (like a hospital) does not do what you ask in your advance directive.

Health Facility Licensing and Certification Program
Mail to: 800 NE Oregon Street, Suite 465
Portland, OR 97322
Email: mailbox.hclc@odhsoha.oregon.gov
Fax: 971-673-0556
Online:
https://www.oregon.gov/OHA/PH/ProviderPartnerResources/HealthcareProvidersFacilities/HealthcareHealthCareRegulationQualityImprovement/Pages/index.aspx

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

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 https://www.oregon.gov/OHA/PH/ProviderPartnerResources/HealthcareProvidersFacilities/HealthcareHealthCareRegulationQualityImprovement/Pages/index.aspx. Send your complaint to:

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

Reporting Fraud, Waste, and Abuse

We're a community health plan, and we want to make sure that 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:

ODHS Fraud Investigation Unit
PO Box 14150
Salem, OR 97309
Hotline: 1-888-FRAUD01 (888-372-8301)
Fax: 503-373-1525 Attn: Hotline
Online: https://www.oregon.gov/odhs/financial-recovery/Pages/fraud.aspx

OR (specific to providers)

OHA Office of Program Integrity (OPI)
500 Summer Street NE, E-36
Salem, OR 97301
Hotline: 1-888-FRAUD01 (888-372-8301)
Online: 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
E-mail: Medicaid.Fraud.Referral@doj.state.or.us
Online: https://www.doj.state.or.us/consumer-protection/sales-scams-fraud/medicaid-fraud/

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 PO 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. To support your appeal, you have the right to: • Give information and testimony in person or in writing. • Make legal and factual arguments in person or in writing. You must do these things within appeal timeframes listed below. **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 have the right to 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.

Providers should not deny a service. They have to ask PacificSource Community Solutions if you can get approval for a service.

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 to your appeal, 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 online hearing form at https://bit.ly/ohp-hearing-form.

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, or your authorized representative, with your written permission, 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 the decision is effective, whichever is later. You can ask by phone, letter, or fax.

- 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
PO 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.

Early and Periodic Screening Diagnostic and Treatment (EPSDT) – The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program offers comprehensive and preventive health care services to individuals under the age of 21 who are covered by the Oregon Health Plan (OHP). EPSDT provides EPSDT Medically Necessary and EPSDT Medically Appropriate Medicaid-covered services to treat any physical, dental, vision, developmental, nutritional, and mental and behavioral health conditions. Coverage for EPSDT includes all services coverable under the Oregon Health Plan (OHP), when EPSDT Medically Necessary and EPSDT Medically Appropriate for the EPSDT individual.

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*.

Health Risk Assessment – A survey about a member's health. The survey asks about emotional and physical health, behaviors, living conditions and family history. CCOs use it to connect members to the right help and support.

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 Outpatient Services – When surgery or treatment is performed in a hospital and you leave afterward.

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. Work with your 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.