2024 Member Handbook

health share
Health Share of Oregon

Your health plan. Your choice.
HealthShareOregon.org

Health Share of Oregon

Member Handbook

Health Share Customer Service

www.HealthShareOregon.org
Call: 503-416-8090 Toll Free: 888-519-3845 TTY/TDD: 711 Fax: 503-459-5749
2121 SW Broadway #200, Portland, OR 97201
Office Hours: Monday-Friday 8:00 a.m.-5:00 p.m. Our office is wheelchair accessible.

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Handbook updates

Health Share of Oregon mails a member handbook to newly enrolled or reenrolled members when Oregon Health Authority (OHA) notifies us that you are enrolled in Oregon Health Plan (OHP), as is required by federal law. Here is where you can find the most up to date handbook https://www.healthshareoregon.org/members/my-health-plan/member-handbook. If you need help or have questions, call Customer Service at 503-416-8090, or toll free at 888-519-3845 (TTY/TDD 711).

Getting started.

If you are looking for:

Your Health Share ID card.

Always carry your OHP and Health Share member ID cards with you.

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

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

- Your Name
- Your ID Numbers
- 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 _____

Free help in other languages and formats.

Everyone has a right to know about Health Share's programs and services. All members have a right to know how to use our programs and services.

We give these kinds of free help:

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

You can find this member handbook on our website at: healthshareoregon.org. If you need help or have questions, call Customer Service at 503-416-8090, or toll free at 888-519-3845 (TTY/TDD 711).

Get information in another language or format.

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

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

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

You can ask for materials electronically. Email us at info@healthshareoregon.org or call Customer Service at 503-416-8090 or toll free at 888-519-3845 (TTY/TDD 711). Please let us know which documents you would like emailed to you.

You can have an interpreter.

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

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

If you need assistance, please call us at 503-416-8090, or toll free at 888-519-3845 TTY/TDD 711 or call OHP Client Services at 800-273-0557 (TTY 711). See page 152 for "Complaint, appeal and hearing rights."

If you do not get the interpreter help you need, call the state's Language Access Services Program coordinator at 844-882-7889, TTY 711 or email: LanguageAccess.Info@odhsoha.oregon.gov.

ENGLISH

You can get this handbook in other languages, large print, Braille, or a format you prefer. You can also ask for an interpreter. This help is free. Call 503-416-8090 or toll free at 888-519-3845 TTY/TDD 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 503-416-8090, o TTY/TDD 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. 503-416-8090 или TTY/TDD 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 503-416-8090 hoặc TTY (Đường dây Dành cho Người Khiếm thính hoặc Khuyết tật về Phát âm). 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 الخطاب 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 على888-519-3845أو المبرقة الكاتبة 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 888-519-3845 ama TTY 711. Waa aqbalnaa wicitaanada gudbinta.

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

SIMPLIFIED CHINESE

您可获取本文件的其他语言版、大字版、盲文版或您偏好的格式版本。您还可要求提供口译员服务。本帮助免费。致电888-519-3845或TTY 711。我们会接听所有的转接来电。

您可以从经过认证且合格的医疗口语翻译人员那里获得帮助。

TRADITIONAL CHINESE

您可獲得本信函的其他語言版本、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 888-519-3845 或聽障專線711。我們接受所有傳譯電話。

您可透過經認證的合格醫療保健口譯員取得協助。

KOREAN

이 서신은 다른 언어, 큰 활자, 점자 또는 선호하는 형식으로 받아보실 수 있습니다. 통역사를 요청하실 수도 있습니다. 무료 지원해 드립니다. 888-519-3845또는 TTY 711에 전화하십시오. 저희는 중계 전화를 받습니다.

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

HMONG

Koj txais tau tsab ntawv no ua lwm yam lus, ua ntawv loj, ua lus Braille rau neeg dig muag los sis ua lwm yam uas koj nyiam. Koj kuj thov tau kom muaj ib tug neeg pab txhais lus. Txoj kev pab no yog ua pub dawb. Hu 888-519-3845 los sis TTY 711. Peb txais tej kev hu xov tooj rau neeg lag ntseg.

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

MARSHALLESE

Kwomaroñ bōk leta in ilo kajin ko jet, kōn jeje ikkillep, ilo braille ak bar juon wāwein eo eṃṃanḷọk ippaṃ. Kwomaroñ kajjitōk bwe juon ri ukōt en jipañ eok. Ejjeḷọk wōṇāān jipañ in. Kaaltok 888-519-3845 ak TTY 711. Kwomaroñ kaaltok in relay.

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

CHUUKESE

En mi tongeni angei ei taropwe non pwan ew fosun fenu, mese watte mak, Braille ika pwan ew format ke mwochen. En mi tongeni pwan tingor emon chon chiaku Ei aninis ese fokkun pwan kamo. Kokori 888-519-3845 ika TTY 711. Kich mi etiwa ekkewe keken relay.

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

TAGALOG

Makukuha mo ang liham na ito sa iba pang mga wika, malaking letra, Braille, o isang format na gusto mo. Maaari ka ring humingi ng tagapagsalin. Ang tulong na ito ay libre. Tawagan ang 888-519-3845 o TTY 711. Tumatanggap kami ng mga relay na tawag.

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

GERMAN

Sie können dieses Dokument in anderen Sprachen, in Großdruck, in Brailleschrift oder in einem von Ihnen bevorzugten Format erhalten. Sie können auch einen Dolmetscher anfordern. Diese Hilfe ist gratis. Wenden Sie sich an 888-519-3845 oder per Schreibtelefon an 711. Wir nehmen Relaisanrufe an.

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

PORTUGUESE

Esta carta está disponível em outros idiomas, letras grandes ou braile, se preferir. Também poderá solicitar serviços de interpretação. Essa ajuda é gratuita. Ligue para 888-519-3845 ou use o serviço TTY 711. Aceitamos encaminhamentos de chamadas.

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

JAPANESE

この書類は、他の言語に翻訳されたもの、拡大文字版、点字版、その他ご希望の様式で入手可能です。また、通訳を依頼することも可能です。本サービスは無料でご利用いただけます。888-519-3845または TTY 711 までお電話ください。電話リレーサービスでも構いません。

認定または有資格の医療通訳者から支援を受けられます。

UKRAINIAN

Ви можете отримати цей довідник іншими мовами, крупним шрифтом, шрифтом Брайля або у форматі, якому ви надаєте перевагу. Ви також можете попросити надати послуги перекладача. Ця допомога є безкоштовною. Дзвоніть по номеру телефону 503-416-8090, or toll free at 888-519-3845 або телетайпу #TTY711. Ми приймаємо всі дзвінки, які на нас переводять.

Ви можете отримати допомогу від сертифікованого та кваліфікованого медичного перекладача.

Our nondiscrimination policy.

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

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

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

Make (or file) a complaint with Health Share in any of these ways:

Phone: Call our Grievance Coordinator at 503-416-1459 (TTY/TTD 711)
Fax: 503-459-5749
Mail: Health Share
2121 SW Broadway, Suite 200
Portland, OR 97201
Email: info@healthshareoregon.org
Web: http://www.healthshareoregon.org/members/get-help/member-rights/appeals-and-grievances

Need help filing a complaint? Call Customer Service at 503-416-8090 or toll free at 888-519-3845 (TTY/TDD 711).

You also have a right to file complaint with any of these organizations:

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

Bureau of Labor and Industries Civil Rights Division
Phone: 971-673-0764
Web: https://www.oregon.gov/boli/civil-rights/Pages/default.aspx
Email: BOLI_help@boli.oregon.gov
Mail: Bureau of Labor and Industries Civil Rights Division
800 NE Oregon St., Suite 1045
Portland, OR 97232

U.S. Department of Health and Human Services Office for Civil Rights (OCR)
Web: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Phone: 800-368-1019, TDD: 800-537-7697
Email: 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. Email info@healthshareoregon.org to let us know. You can ask us for a list of who we have shared your records with.

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

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

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

What's in this handbook

Welcome to Health Share!

We are glad you are part of Health Share. Health Share 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 Health Share, how to get care, and how to get the most from your benefits.

How OHP and Health Share work together.

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

OHP has local health plans that help you use your benefits. The plans are called Coordinated Care Organizations or CCOs. Health Share is a CCO. Health Share serves Multnomah County, Washington County and Clackamas County. We work with other organizations to help manage certain parts of your benefit, for example dental and transportation. For a full list of the organizations and descriptions of the services they offer see page 24.

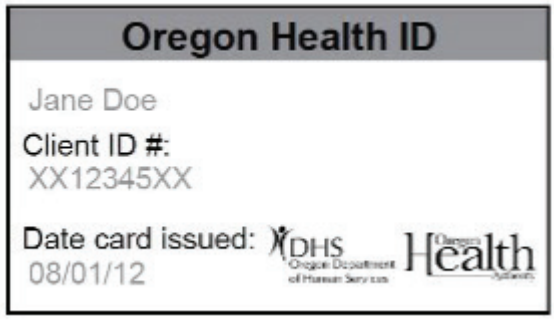
CCOs organize and pay for your health care. We pay doctors or providers in different ways to improve how you get care. This helps make sure providers focus on improving your overall health. You have a right to ask about how we pay providers. Provider payments or incentives will not change your care or how you get benefits. For more information, call

Customer Service at 503-416-8090, or toll free at 888-519-3845 (TTY/TDD 711).

All CCOs offer the same OHP benefits. Some offer extra services like new baby items and gym memberships. Learn more about Health Share benefits on page 48.

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 Health Share member and lists other information like important phone numbers. Your Primary Care Provider (PCP) will also be listed on your ID card.

Your Health Share ID card will look like:

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

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

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

The following medical health plans also send their members separate ID cards:

- Kaiser Permanente
- OHSU Health

If you select one of these plans, you will use this separate ID card when checking into an appointment or using the pharmacy (you can also use your Health Share ID card at the pharmacy).

If you select CareOregon, Providence Health Assurance or Legacy Health PacificSource health plans, you can use your Health Share card at appointments and the pharmacy.

And whichever plan you pick, you can find important phone numbers on your Health Share ID card, including: your physical health plan and Primary Care Provider, dental health plan and primary dental provider, mental health and substance use plan, and our non-emergency medical transportation provider, Ride to Care.

Contact us.

The Health Share office is open Monday through Thursday, from 8:00 a.m. to 5:00 p.m. 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.

We are closed on New Year's Day (1/1/2024), Martin Luther King Jr Day (1/15/2024), President's Day (2/19/2024), Memorial Day (5/27/2024), Juneteenth (6/19/2024), Independence Day (7/4/2024), Thanksgiving (11/28/2024), Friday after Thanksgiving (11/29/2024), Christmas Eve (12/24/2024), and Christmas (12/25/2024).

Our office location is:

Health Share of Oregon
2121 SW Broadway, Suite 200
Portland, OR 97201
Call **toll free** at 888-519-3845 (TTY/TDD 711)
Fax: 503-459-5749
Online: https://www.healthshareoregon.org/about/contact

Important phone numbers.

Call Customer Service 503-416-8090, or toll free at 888-519-3845, TTY users, please call 711.

Choose a plan that meets your needs.

Health Share allows you to choose medical and dental health plans to meet the needs of you and your family. When you enroll in Health Share, you will be automatically assigned to a plan based on factors such as your current providers and where you live. The plans assigned to you are listed on your Health Share ID card. If you want to switch your plan, call us at: 503-416-8090, or toll free at 888-519-3845, TTY users, please call 711.

Medical Plans

CareOregon	
800-224-4840	careoregon.org
Kaiser Permanente	
800-813-2000	kp.org
Legacy Health PacificSource	
877-500-2680	pacificsource.com/medicaid/about-medicaidohp/our-coordinated-care-organizations
OHSU Health	
844-827-6572	ohsu.edu/health-services
Providence Health Assurance	
800-898-8174	providencehealthplan.com/health-share-providence-ohp

Learn more about medical benefits and care on page 48.

Pharmacy Plans

Your pharmacy benefits are managed by your medical health plan. For any questions, please call your plan at the numbers listed above.

Learn more about pharmacy benefits on page 102.

Dental Plans

Advantage Dental Services	
866-268-9631	advantagedentalservices.com
CareOregon Dental	
888-440-9912	careoregondental.org
Kaiser Permanente NW	
800-813-2000	kaiserpermanentedentalnw.org
ODS Community Health Dental Plan	
800-342-0526	odscommunitydental.com/members
Willamette Dental Group	
855-433-6825	willamettedental.com

Learn more about dental health benefits and care on page 66.

Behavioral Health, Mental Health & Substance Use Disorder Treatment

You can receive mental health care and substance use disorder treatment through an in-network behavioral health provider, and it is covered by CareOregon.

CareOregon	
800-224-4840	careoregon.org/members/mental-health-and-substance-use-treatment

Learn more about behavioral health benefits and care on page 64.

Non-emergency medical transportation.

Free rides to physical care, dental care, or behavioral health care through Ride to Care

You can get a free ride to physical care, dental care, and behavioral health visits. Call 503-416-3955 local or 855-321-4899 toll-free to set up a ride. TTY users, please call 711.

Hours: Monday through Friday, 8:00 a.m. to 5:00 p.m. Our customer service team is not available on holidays. We are closed on New Year's Day (1/1/2024), Martin Luther King Jr Day (1/15/2024), President's Day (2/19/2024), Memorial Day (5/27/2024), Juneteenth (6/19/2024), Independence Day (7/4/2024), Thanksgiving (11/28/2024), Friday after Thanksgiving (11/29/2024), Christmas Eve (12/24/2024), and Christmas (12/25/2024).

Learn more about rides to care on page 92.

Contact the Oregon Health Plan.

OHP Customer Service can help:

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

How to contact OHP Customer Service.

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

Your rights and responsibilities

As a member of Health Share, you have rights. There are also responsibilities or things you must do when you get OHP. If you have any questions about the rights and responsibilities listed here, call Customer Service at Call 503-416-8090, or toll free at 888-519-3845 (TTY/TDD 711).

You have the right to exercise your member rights without a bad response or discrimination. You can make a complaint if you feel like your rights have not been respected. Learn more about making complaints on page 152. You can also call an Oregon Health Authority Ombudsperson at 877-642-0450 (TTY 711). You can send them a secure email at www.oregon.gov/oha/ERD/Pages/Ombuds-Program.aspx.

There are times when people under age 18 (minors) may want or need to get health care services on their own. To learn more, read "Minor Rights: Access and Consent to Health Care." This booklet tells you the types of services minors can get on their own and how their health records may be shared. You can read it at https://www.oregon.gov/oha/ph/healthypeoplefamilies/youth/pages/resources.aspx. Click on "Understanding Minor Consent and Confidentiality in Health Care in Oregon" Or go to: https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le9541.pdf.

Your rights as an OHP member.

You have the right to be treated like this

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

You have the right to get this information

- Materials explained in a way and in a language you can understand. (See page 5).
- Materials that tell you about CCOs and how to use the health care system. (Member Handbook is one good source for this).
- Written materials that tell you your rights, responsibilities, benefits, how to get services, and what to do in an emergency. (Member Handbook is one good source for this).
- Information about your condition, treatments, and alternatives, what is covered, and what is not covered. This information will help you make good decisions about your care. Get this information in a language and a format that works for you.
- A health record that keeps track of your conditions, the services you get, and referrals. (See page 15).
    - 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 Health Share. (See page 38).
- Be told in a timely manner if an appointment is cancelled.

You have the right to get this care

- Care and services that put you at the center. Get care that gives you choice, independence, and dignity. This care will be based on your health needs and meet standards of practice.
- Services that consider your cultural and language needs and are close to where you live. If available, you can get services in non-traditional settings such as online. (See page 85).
- Care Coordination, community-based care, and help with care transitions in a way that works with your culture and language. This will help keep you out of a hospital or facility.
- Services that are needed to know what health condition you have.
- Help to use the health care system. Get the cultural and language support you need. (See page 5). This could be:
    - Certified or qualified health care interpreters.
    - Certified Traditional Health Workers.
    - Community health workers.
    - Peer wellness specialists.
    - Peer support specialists.
    - Doulas.
    - Personal health navigators.
- Help from CCO staff who are fully trained on CCO policies and procedures.
- Covered preventive services. (See page 48).
- Urgent and emergency services 24 hours a day, 7 days a week without approval or permission. You can get emergency care at any hospital. For a directory of network hospitals, see page 107.
- Referrals to specialty providers for covered coordinated services that are needed based on your health. (See page 44).
- Extra support from an OHP Ombudsperson. (See page 28).

You have the right to do these things

- Choose your providers and to change those choices. (See page 36).
- Get a second opinion. (See page 41).
- 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 a referral from a provider.
- Make a statement of wishes for treatment. This means your wishes to accept or refuse medical, surgical, or behavioral health treatment. It also means the right to make directives and give powers of attorney for health care, listed in ORS 127. (See page 143).
- Make a complaint or ask for an appeal. Get a response from Health Share when you do this. (See page 152).
    - Ask the state to review if you don't agree with Health Share's decision. This is called a hearing.
- Get free certified or qualified health care interpreters for all non-English languages and sign language. (See page 5).

Your responsibilities as an OHP member.

You must treat others this way

- Treat Health Share staff, providers, and others with respect.
- Be honest with your providers so they can give you the best care.

You must tell OHP this information

Call OHP/ONE Customer Service Line at 800-699-9075 (TTY 711) when you:

- Move or change your mailing address.
- If any family moves in or out of your home.
- Change your phone number.
- Become pregnant and when you give birth.
- Have other insurance.

You must help with your care in these ways

- Choose or help choose your Primary Care Provider or clinic.
- Get yearly checkups, wellness visits, and preventive care to keep you healthy.
- Be on time for appointments. If you will be late, call ahead or cancel your appointment if you can't make it.
- Bring your medical ID cards to appointments. Tell the office that you have OHP and any other health insurance. Let them know if you were hurt in an accident.
- Help your provider make your treatment plan. Follow the treatment plan and actively take part in your care.
- Follow directions from your providers' or ask for another option.
- If you don't understand, ask questions about conditions, treatments, and other issues related to care.
- Use information you get from providers and care teams to help you make informed decisions about your treatment.
- Use your Primary Care Provider for tests 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 Health Share.
- Use urgent or emergent services appropriately. Tell your Primary Care Provider within 72 hours if you do use these services.
- Help providers get your health record. You may have to sign a form for this.
- Tell Health Share if you have any issues, complaints, or need help.
- Pay for services that are not covered by OHP.

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 on page 50.

American Indian and Alaska Natives don't need a referral or permission to get care from these providers. These providers must bill Health Share. 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 Health Share any time and have OHP Fee-For-Service (FFS) pay for their care. Learn more about leaving or changing your CCO on page 135.

New members who need services right away.

Members who are new to OHP or Health Share 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 Health Share:

- Call Care Coordination at 503-416-8090 or toll free at 888-519-3845 (TTY/TDD 711). They can help you get the care you need. Care Coordination can help OHP members with Medicare, too. (See page 44 for Care Coordination).
- Make an appointment with your PCP as soon as you can. You can find their name and number on your Health Share ID card.
- Call Customer Service at 503-416-8090 or toll free at 888-519-3845 (TTY/TDD 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 your medical health plan. You can pick a PCP by visiting your health plan's provider directory, then calling either your medical plan or Health Share Customer Service at 888-519-3845 (TTY/TDD 711). If you do not pick a provider within 90 days of becoming a member, Health Share will assign you to a clinic or PCP within your medical plan. Health Share will notify your PCP of the assignment and send you a letter with your provider's information.

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 Health Share about a dentist, mental health provider, and pharmacy. Health Share members are assigned to CareOregon for Mental and Behavioral Health Care.

We assign your dental plan based on who you have seen in the past year and a half. If you haven't seen anyone, we assign you to a dental plan that works closely with your medical health plan. If your Primary Care Provider is a Federally Qualified Health Center (FQHC) you will be assigned accordingly. You will go to them for most of your dental needs. They will send you to a specialist if you need to go to one.

Your Primary Care Dentist (PCD) is important because they:

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

If you are not happy with your Primary Care Dentist, you can call Health Share to switch to a different one. There is no limit on how many times you may change your dentist.

To choose a mental health provider, use this directory to search by location, specialties, language and more https://healthshare-bhplan-directory.com. You may also call Customer Service for help finding a provider that meets your needs.

To choose a pharmacy, contact your health plan or call Health Share Customer Service for assistance at 888-519-3845 (TTY/TDD 711).

CareOregon	
800-224-4840	careoregon.org
Kaiser Permanente	
800-813-2000	kp.org
Legacy Health PacificSource	
877-500-2680	pacificsource.com/medicaid/about-medicaidohp/our-coordinated-care-organizations
OHSU Health	
844-827-6572	ohsu.edu/health-services
Providence Health Assurance	
800-898-8174	providencehealthplan.com/health-share-providence-ohp

Changes to your provider.

You can change your Primary Care Provider by contacting your medical health plan. Please call Customer Service at 503-416-8090 or toll free at 888-519-3845 (TTY/TDD 711) Monday through Friday, 8:00 a.m. to 5:00 p.m. if you would like to change your PCP, PCD or other providers. **You can start seeing your new Primary Care Provider (PCP), Primary Care Dentist (PCD) or other providers on the day this change is made.** If there is a change and your PCP is no longer contracted with Heath Share, we will send you a letter 30 days before the change happens. If this change was already made, we will send you a letter within 15 days of the change.

In-network providers.

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

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

- You are switching CCOs or move from OHP fee-for-service to a CCO (see page 140).
- You are American Indian or Alaskan Native (see page 34).

Provider directory.

You can choose your PCP, PCD or other providers from the provider directories at: https://providers.healthshareoregon.org/. You can also call Customer Service or your medical health plan for help.

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

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

You can get a paper copy. You can get it in another format (such as other languages, large print, or Braille) for free. Call Customer Service at 503-416-8090 or toll free at 888-519-3845 (TTY/TDD 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 Health Share member.
- Your name and Health Share ID number.
- What kind of appointment you need.
- If you need an interpreter and the language you need.

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

You can get a free ride to your appointment. Learn more about free rides to care on page 92.

Missed appointments.

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

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

Changes to Health Share providers.

We will tell you when one of your regular providers stops working with Health Share. 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 Health Share Customer Service at 503-416-8090, or toll free at 888-519-3845 (TTY/TDD 711) 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 Health Share Customer Service for help. We will arrange the second opinion for free.

Survey about your health.

Your medical health plan will contact you to take a survey within 90 days of signing up. For long-term care or long-term service or support, the survey will be sent within 30 days or as soon as your health allows. The survey will be mailed to you, but your health plan may also call you and ask if you'd like to take the survey over the phone and may send reminders if they haven't heard from you.

The survey asks questions about your general health with the goal of helping reduce health risks, maintain health, and prevent disease.

The survey asks about:

- Your access to food and housing.
- Your habits (like exercise, eating habits, and if you smoke or drink alcohol).
- How you are feeling (to see if you have depression or need a mental health provider).
- Your general well-being, oral health, and medical history.
- Your primary language.
- Any special health care needs (like 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 page 44 for Care Coordination.

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

If you want a survey sent to you, you can call your medical health plan or Health Share Customer Service at 503-416-8090 or toll free at 888-519-3845 (TTY/TDD 711), and we will send you one.

Your survey may be shared with your doctor or other providers. Your health plan will ask for your permission before sharing your survey with providers.

Prevention is important.

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

Some examples of preventive services:

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

A healthy mouth also keeps your heart and body healthier.

If you have any questions, please call us at 503-416-8090, or toll free at 888-519-3845 (TTY/TDD 711).

Members who are pregnant.

If you are pregnant, OHP provides extra services to help keep you and your baby healthy. When you are pregnant, Health Share can help you get the care you need. It can also cover your delivery and your care for one year after your pregnancy.

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

- **Tell OHP that you're pregnant as soon as you know.** Call 800-699-9075 (TTY 711) or login to your online account at ONE.Oregon.gov.
- **Tell OHP your due date.** You do not have to know the exact date right now. If you are ready to deliver, call us right away.
- **Ask us about your pregnancy benefits.** You can get extra benefits when you're pregnant, like eyeglasses and extra dental benefits.

After you deliver:

- **Call OHP or ask the hospital to send a newborn notification to OHP.** OHP will cover your baby from birth. Your baby will also have Health Share.
- **Get a free nurse home visit with Family Connects Oregon (Available in Washington County).** This nurse home visiting program is free for all families with newborns. A nurse will come to you for a check-up, newborn tips, and resources.

Get help organizing your care with Care Coordination

Care Coordination helps you better use and understand your benefits and brings all of your providers together so that you get the best possible care.

Your medical health plan is the primary point of contact for Care Coordination. If you are currently enrolled in Care Coordination, your medical plan will send you a letter listing either your specific Care Coordinator and their phone number or the Care Coordination department phone number. Please call them with any needs or to set up care.

You may also be contacted by your health plan after taking the Survey About Your Health if they think you would benefit from Care Coordination.

Depending on your needs, you might also be connected to Care Coordination through your primary care team, the CareOregon behavioral health plan or your dental plan. Health Share members may also have access to specialized county-based teams that provide enhanced behavioral health Care Coordination.

If you change medical health plans, your Care Coordination team may also change. You will receive a letter from your new plan listing either your new Care Coordinator and their phone number or the Care Coordination department phone number.

You or someone speaking on your behalf can ask for Care Coordination at any time. Call your health plan or Health Share Customer Service at 503-416-8090 or 888-519-3845 (TTY/TDD 711) or visit healthshareoregon.org/members for more information about Care Coordination.

Working together for your care.

Your Care Coordination team will work closely with you. They will connect you with community and social supports that may help you. This team will include different people who will work together to meet your needs, such as providers, specialists, and community programs you work with.

You and your assigned care team will make a care plan together. Your care plan will list supports and services needed to help you reach your goals. This plan addresses medical, dental, cultural, developmental, behavioral, and social needs so you have positive health and wellness results. The plan will be reviewed and updated at least annually, and as your needs change or if you ask for it. You will get a copy of your care plan.

Your Care Coordination team will:

- Help you navigate and understand your benefits and how they work.
- Use care programs to help you manage chronic health conditions such as diabetes, heart disease and asthma.
- Connect you to resources and providers who can help you with your behavioral health concerns and substance use disorders, when necessary.
- Help with finding ways to get the right services and resources to make sure you feel comfortable, safe, and cared for.
- Help you pick a Primary Care Provider (PCP).
- Help you understand any medical advice or details about your care.
- 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 work together to deliver the best care possible.
- Create a care plan with you that meets your health needs.

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

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

Care Coordination availability.

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

Call Health Share Customer Service at 503-416-8090 or toll free at 888-519-3845 (TTY/TDD 711) for assistance and further information about Care Coordination.

You also can call Care Coordinators at your health care plan:

CareOregon	503-416-4100
Kaiser Permanente	503-721-6435
Legacy Health PacificSource	888-970-2507
OHSU Health	844-827-6572
Providence Health Assurance	503-574-7247

Members with Medicare.

You can also get help with your OHP and Medicare benefits. A Care Coordinator 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. Oregon decides what services to pay for based on the **Prioritized List of Health Services**. This list is made up of different medical conditions (called diagnoses) and the types of procedures that treat the conditions. A group of medical experts and ordinary citizens work together to develop the list. This group is called the Oregon Health Evidence Review Commission (HERC). They are appointed by the Governor.

The list has combinations of all the conditions and their treatments. These are called condition/treatment pairs.

The condition/treatment pairs are ranked on the list by how serious each condition is and how effective each treatment is.

For members aged 21 and older:

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

For members under age 21:

All medically necessary and medically appropriate services must be covered, based on your individual needs and medical history. This includes items "below the line" on the Prioritized List as well as services that don't appear on the Prioritized List, like

Durable Medical Equipment. See page 80 for more information on coverage for members under 21.

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

Direct access.

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

No referral or preapproval needed.

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

These services do not need a referral or preapproval:

- **Emergency services**
  For physical, dental, or behavioral health
- **Urgent care services**
  For physical, dental, or behavioral health
- **Family planning services**
- **Women's health services**
  For routine and preventive care
- **Sexual abuse exams**
- **Behavioral Health assessment and evaluation services**
- **Outpatient and peer-delivered behavioral health services**
  From an in-network provider
- **Care Coordination services**
  Available for all members

Getting preapproval.

Some services, like surgery or inpatient services, need approval before you get them. This is to make sure that the care is medically needed and right for you. Your provider will take care of this. Sometimes your provider may submit information to us to support you getting the service. Even if the provider is not required to send us information, Health Share may still need to review your case to make sure that you should receive the service.

These decisions are based only on whether the care or service is right for you and if you are covered by Health Share. Health Share 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 Health Share Customer Service at 503-416-8090, or toll free at 888-519-3845 (TTY/TDD 711) if you:

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

You might not get the service if it is not approved. We review preapproval requests as quickly as your health condition requires. Most service decisions are made within 14 days. Sometimes a decision may take up to 28 days. This only happens when we are waiting for more information. If you or your provider feel following the standard time frame puts your life, health, or ability to function in danger, we can make an "expedited service authorization" decision. Expedited service decisions are typically made within 72 hours, but there may be a 14-day extension. You have the right to complain if you don't agree with an extension decision. See page 152 for how to file a complaint.

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

See page 102 to learn about prescriptions.

You do not need approval for emergency or urgent services or for emergency aftercare services. See page 119 to learn about emergency services.

Services that need preapproval:

- **Inpatient hospital services**
- **Inpatient Substance Use Disorder residential and detox services**
- **Medication assisted treatment for Substance Use Disorder**
  First 30 days of treatment do not need preapproval
- **Out-of-network Substance Use Disorder services**
- **Partial or complete dentures**
- **Crowns**
- **Root canal therapy on molars**

Health Share may require preapproval for services that are not listed here.

Provider referrals and self-referrals.

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

Your medical health plan reviews referrals from your provider and decides if they should be approved or if another provider can perform the service.

For example: If your PCP/PCD cannot give you services you need, they can refer you to a specialist. If preapproval is needed for the service, your provider will ask your medical health plan for approval.

Ideally, you would work with a specialist within your medical health plan network, where providers are more familiar with your needs. When that isn't possible, you can work with your medical health plan to find an out-of-network specialist or change your medical health plan to choose from a different network of specialists. There is no extra cost if this happens.

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

Services that need a referral:

- **Medication assisted treatment for Substance Use Disorder**
- **Specialist services**
  If you have special health care needs, your health care team can work together to get you access to specialists without a referral

If you use a dental care provider that is not your Primary Care Dentist, you may need a referral for dental services.

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

A **self-referral** means you can look in the provider directory to find the type of provider you would like to see. You can call that provider to set up a visit without a referral from your provider. Learn more about the Provider Directory on page 39.

Services you can self-refer to:

- Visits with your PCP
- Care when you have an emergency
- Services from your OB/GYN in your network for routine or preventive services
- Care for sexually transmitted infections (STIs)
- Immunizations (shots)
- Traditional Health Worker (THW) services
- Routine vision providers in the network
- Dental providers in the network
- Family planning services
- Mental health services for problems with alcohol or other drugs
- Assertive community treatment

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

Benefits charts icon key:

Services that may need preapproval

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

Services that need a referral

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

No referral or preapproval needed

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

Physical health benefits.

See the next page 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. Health Share will coordinate services for free if you need help.

If you see an * in the benefit charts, this means a service may be covered beyond the limits listed for members under 21 if medically necessary and appropriate. Please see page 80 to learn more.

Service	How to access	Who can get it
Care Coordination Services Includes coordination between providers, help with chronic conditions and connections to social services.	 No referral or preapproval	All members
Comfort Care & Hospice Services Managing symptoms, pain, and anxiety at the end of life. Hospice services are covered for clients who have been certified as terminally ill.	 Preapproval needed	All members
Diagnostic Services These services help find a diagnosis, and might include tests, exams or procedures. As recommended, check with your PCP or mental health provider. Services are subject to Diagnostic Guidelines on the Prioritized List of Health Services. Coverage is based on the OHP Guidelines and there may be limitations based on your medical need.	 Preapproval needed	All members
Durable Medical Equipment Durable medical equipment (DME) includes supplies and equipment that don't wear out (like walkers, diabetic supplies, prosthetics). Coverage is based on the OHP Guidelines and there may be limitations based on your medical need.	 Preapproval needed	All members

Service	How to access	Who can get it
Well-Child Care, Early & Periodic Screening, Diagnosis and Treatment (EPSDT) services* EPSDT covers all medically necessary and medically appropriate services for members under 21, including screenings and assessments of physical and mental health development. See page 80 for more information.	Referral or preapproval may be needed	Members ages 0-20 years old
Elective Surgeries/Procedures These are surgeries and procedures you choose to have and can be scheduled in advance. Coverage is based on the OHP Guidelines and certain requirements must be met to receive services.	 Preapproval needed	Contact your medical plan
Emergency Medical Transportation An example of this type of transportation is an ambulance. It can take you to a hospital or provider when you have an emergency need. No limit See page 119 for more information.	 No referral or preapproval	All members
Emergency Services This is immediate medical help, often in a hospital, when you have an emergency — like trouble breathing or bleeding that won't stop — and when urgent care or your provider's office are not available. No limit; not covered outside U.S. or U.S. territories. See page 119 for more information.	 No referral or preapproval	All members

Service	How to access	Who can get it
Family Planning Services These services help you plan for having children (or deciding not to), including the number and timing of your children. No limit. Some examples are birth control and annual exams. Some family planning services can be obtained from out-of-network providers.	 No referral or preapproval	All members
Gender Affirming Care This care includes puberty suppression, primary care and specialist doctor visits, mental health care visits, hormone therapy, lab work, and some surgeries. Coverage is based on OHP guidelines and certain requirements must be met to receive services.	Approval based on OHP guidelines Contact your medical plan	All members
Hearing Services* These services include things to test hearing or help you hear better, like audiology and hearing aids. Members 21 years and older who meet criteria are limited to one hearing aid every five years (two may be authorized if certain criteria are met). Members under 21 years old who meet criteria are allowed two hearing aids every three years, or as medically necessary.	Referral or preapproval may be needed for some services	All members
Home Health Services* These services are provided in your home, often during an illness or after an injury. They include things like physical therapy and occupational therapy. Coverage is based on the Oregon Administrative Rules and there may be limitations based on your medical need. Call Customer Service for details.	Referral or preapproval may be needed for some services	All members

Service	How to access	Who can get it
Immunizations and Travel Vaccines Vaccines to help keep you healthy — like yearly flu or COVID shots — or that you might need before you travel. No limit for vaccines recommended by the CDC.	 No referral or preapproval	All members
Inpatient Hospital Services Medically necessary services that require you to stay in the hospital overnight. Number of days based on your health plan's approval. Approval is based on whether the service needed is covered or medically necessary/appropriate.	 Preapproval needed	All members
Interpreter Services Having someone at your appointments, on health care calls, or for other health care-related needs who can interpret in the language of your choice. No limit.	 No referral or preapproval	All members
Laboratory Services, X-Rays, and other Procedures These are tests your provider might ask for to check your health, things like: blood tests, urine tests and X-rays. Check with your PCP for blood draws and X-rays. Authorization required for CT scans or MRIs.	 No referral or preapproval	All members
Maternity Services These are services you receive before during and after childbirth, including: prenatal visits with your provider, newborn care (first 28 days after birth) and postpartum care (care for the birthing parent for up to six months after the baby is born). No limit.	 No referral or preapproval	Pregnant members

Service	How to access	Who can get it
Rides to Care, also called Non-Emergent Medical Transportation (NEMT) Services These services make it possible to get to your medical appointments at no cost. Services include mileage reimbursement, transit passes, and rides to your health care appointments. See page 92 for more information, including details about services.	 No referral or preapproval	All members
Outpatient Hospital Services Medically necessary services in a hospital that do not require a hospital stay. Examples include chemo, radiation, and pain management. As recommended. Services are subject to the Prioritized List of Health Services. Coverage is based on the OHP Guidelines and there may be limitations based on your medical need.	 Preapproval needed	All members
Pharmaceutical Services (Prescription Medication) The drugs you need to take to help keep or make you healthy. Many drugs are available with a prescription. A full list of prescription drugs can be found through your plan at https://www.healthshareoregon.org/members/my-health-plan/prescriptions. You may need authorization in addition to your prescription. Your doctor will let you know. Coverage is based on the OHP Guidelines and there may be limitations based on your medical need. They are not paid for by Health Share like other prescription drugs. Your pharmacist will know where to send the bill. Ask your provider about which prescriptions are covered.	Prescription needed	All members

Service	How to access	Who can get it
Physical Therapy, Occupational Therapy, Speech Therapy* These services help you recover normal function for movement and speech. A total of 30 visits per year of rehabilitative therapy and a total of 30 visits per year of habilitative therapy (physical, occupational and speech therapy) are covered when medically appropriate. Additional visits may be approved based on OHP Guidelines and medical necessity.	 Preapproval needed	All members
Preventive Services These are regular appointments and screenings to keep you and your family healthy. Some examples are physical examinations, well-baby care, immunizations, women's health (mammogram, gynecological exam, etc.), screenings (cancer, etc.), diabetes prevention, nutritional counseling, tobacco cessation services, etc. Coverage is based on the OHP Guidelines and there may be limitations based on your medical need and appropriateness.	 No referral or preapproval	All members
Primary Care Provider (PCP) Visits These are regular visits with your doctor, including checkups, non-urgent medical problems, and preventive care. No limit, but you must be assigned to a PCP. See page 36 for more information.	 No referral or preapproval	All members

Service	How to access	Who can get it
Sexual Abuse Exams An examination to provide the victim with necessary care and collect evidence. These take place after sexual abuse, and often include a physical exam and lab tests. You have direct access to these exams. See page 49 for details.	 No referral or preapproval	All members
Specialist Services These are services beyond the routine care you receive from your PCP. Examples include a cardiologist for heart problems, an orthopedist for bone problems, or an endocrinologist for hormone problems or severe diabetes. Coverage is based on OHP guidelines and certain requirements must be met to receive services.	 Preapproval needed	All members For those with special health care needs receiving LTSS, no referral is required
Surgical Procedures There are many types of surgery that may be medically necessary. Examples include heart surgery, tumor removal, or surgery to repair broken bones. Coverage is based on OHP guidelines and certain requirements must be met to receive services. Contact Customer Service for limits.	 Preapproval needed	All members
Telehealth Services Telehealth lets your health care provider care for you without an in-person visit using options like video calling (virtual visits) Telemedical services, and Email visits. See page 98 for more information.	 No referral or preapproval	All members

Service	How to access	Who can get it
Traditional Health Worker (THW) Services A Traditional Health Worker is a person who has similar life experiences to the people they work with. They can assist members in getting services and care that support their wellbeing. Examples include birth doulas, peer support specialists, community health workers, peer wellness specialists and personal health navigators. See page 85 for more information.	 No referral is required	All members
Urgent Care Services These are medical services you receive when your PCP or other normal provider is not available, because your need is more urgent. No limit. See page 110 for more information.	 No referral or preapproval	All members
Women's Health Services (in addition to PCP) for Routine and Preventive Care Preventive services and treatments to keep women healthy including mammograms, hormone therapy, and gynecology. Coverage is based on the OHP Guidelines and there may be limitations based on your medical need.	 No referral or preapproval	All members

Service	How to access	Who can get it
Vision Services* Services designed to keep eyes healthy and, in some cases, correct vision. **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 **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 Examples of medical eye conditions are aphakia, keratoconus, or after cataract surgery.	Referral or Preapproval may be required for treatment of some conditions	Non pregnant adults and members over 21 Members ages 0-20 years old, and pregnant members

The table above is not a full list of services that need preapproval or referral. If you have questions, please call Health Share Customer Service at Call 503-416-8090, or toll free at 888-519-3845 (TTY/TDD 711).

Behavioral health care benefits.

See below for a list of behavioral health benefits that are available to you at no cost. Look at the "Who can get it" column to see if you qualify for the benefit. Look at the "How to access" column to see if you need to get a referral or preapproval for the service. Health Share will coordinate services for free if you need help.

If you see an * in the benefit charts, this means a service may be covered beyond the limits listed for members under 21 if medically necessary and appropriate. Please see page 80 to learn more.

Service	How to access	Who can get it
Assertive Community Treatment (ACT) A team-based approach to help people with severe mental illness live in the community. Examples include crisis interventions; substance use treatment and employment support services. There are no limits for members to receive ACT services.	Screening needed	All members
Wraparound Services Family-driven, youth-guided, process where a Wraparound Care Coordinator organizes supports in a youth's life including family, friends, neighbors, coaches, etc. or professional support like a therapist, child welfare worker, juvenile justice worker, teacher, developmental disabilities worker, etc.) No limit.	Screening needed	Children and youth that meet medical criteria
Behavioral Health Assessment and Evaluation Services This may include questions, mental and physical exams, and other ways providers learn about patients and their possible mental health conditions.	 No referral or preapproval	Direct access (No referral or approval is required) All members

Service	How to access	Who can get it
Behavioral Health Psychiatric Residential Treatment Services (PRTS) These services offer a place where members can stay on a short- or long-term basis while they receive mental health treatment. Call Customer Service about limits. Coverage may be limited based on individual's medical need.	Referral is required and a screening must be completed	Youth under 21 years of age
Inpatient Substance Use Disorder Residential and Detox Services These services offer a place where members can stay on a short- or long-term basis while they receive substance use treatment. Coverage may be limited based on individual's medical need.	 Preapproval needed	All members
Medication For Opioid Use Disorder for Substance Use Disorder (SUD) This treatment uses medicine, counseling and other therapies to help treat substance use. No preapproval needed for the first 30 days of treatment. Coverage may be limited based on individual's medical need.	 Preapproval needed after first 30 days	All members
Outpatient and Peer-delivered Behavioral Health Services from an In-network Provider Services that do not require a hospital or clinic stay and those delivered by a person who has lived experience of mental health issues, addiction or other challenges and has been trained to help those facing similar situations. Examples of these services include counseling, therapy and peer support services.	 No referral or preapproval	All members

Service	How to access	Who can get it
Behavioral Health Specialist Services These are services tailored to specific behavioral health conditions. Examples include psychiatric testing and Electroconvulsive therapy (ECT).	 Preapproval needed	All members
Substance Use Disorder (SUD) Services Services that can help you overcome an addiction and stay drug-free. Examples include detox, behavior therapy, counseling, peer support, etc. Preapproval may be required for out-of-area providers.	 No referral or preapproval	All members

The table above is not a full list of services that need preapproval or referral. If you have questions, please call Health Share Customer Service at Call 503-416-8090, or toll free at 888-519-3845 (TTY/TDD 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:

- Routine 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)
- Denturists (for partials and dentures)
- Pediatric Dentists (for children)
- Periodontist (for gums)
- Orthodontists (in extreme cases, for braces)
- Oral surgeons (for complex extractions)

Please see the table on the next page for what dental services are covered.

All covered services are free. These are covered if your provider says you need the services. Look at the "Service" column to see how many times you can get each service for free. Look At the "How to access" column to see if you need to get a referral or preapproval for the service.

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

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

If you see an * in the benefit charts, this means a service may be covered beyond the limits listed for members under 21 if medically necessary and appropriate. Please see page 80 to learn more.

Service	How to access	Who can get it
Emergency and Urgent Dental Care Care for dental problems that need immediate attention including extreme pain or infection, uncontrolled bleeding or swelling and injuries to teeth or gums.	 No referral or preapproval *No limits	All members
Oral Exams* Dental providers check the health of your teeth and gums, and perform an oral cancer screening. This usually happens during regular check-ups with your Primary Care Dentist. • Members under 21 years old: Twice a year* • All other members: Once a year	 Referral needed if not seeing your Primary Care Dentist	All members
Oral Cleanings* Dental cleanings help with long-term oral health. When you go in for your routine cleaning, the plaque, tartar, and bad bacteria are removed. This helps to minimize the chances of getting cavities. • Members under 19: Twice a year • All other members: Once a year	 No referral or preapproval	All members
Fluoride Varnish* A preventive treatment to help strengthen and protect teeth. • Members through age 18: Twice a year* • Members through age 18 with high risk: Four times per year* • Members 19 years old and up: Once a year* • Members 19 years old and up with high risk: Up to four times per year	 No referral or preapproval	All members

Service	How to access	Who can get it
Oral X-rays X-rays taken of your mouth that help providers get a deeper view of your teeth. Once a year, more covered if medically necessarily and dentally appropriate.	Preapproval may be needed for more than once per year	All members
Sealants* A thin plastic coating used to fill in the grooves on your molars. Under Age 16. On adult back teeth once every 5 years.*	 No referral or preapproval	Members under age 16
Fillings Silver or tooth-colored material used to fill cavities. No limits.	 No referral or preapproval	All members
Partial or complete dentures Dentures are false teeth. Partial dentures fill in spaces from missing teeth. Complete dentures are used when you are missing all of your upper and/or lower teeth. • Partial: Once every 5 years • Complete dentures: Once every 10 years	 Preapproval needed  Referral needed if not seeing your Primary Care Dentist	Members ages 16-years and older

Service	How to access	Who can get it
Crowns Crowns are caps for damaged teeth. Benefits vary by type of crown, specific teeth requiring care, age, and pregnancy status. Contact your dental health plan. • Some upper and lower front teeth • 4 crowns every 7 years	 Preapproval needed  Referral needed if not seeing your Primary Care Dentist	Pregnant members or members under age 21
Extractions Pulling a tooth that needs to be removed to keep you healthy. Must meet criteria for impacted wisdom teeth.	 Preapproval needed for impacted wisdom teeth  Referral needed if not seeing your Primary Care Dentist	All members

Service	How to access	Who can get it
Root Canal Therapy* A root canal is a procedure that repairs decayed or infected teeth. • Under 21: Not covered on third molars (wisdom teeth) • Pregnant members: Covered on first molars • All other members: *Only on front teeth and pre-molars	 Preapproval needed for molars  Referral needed if not seeing your Primary Care Dentist	All members
Orthodontics* In cases such as cleft lip and palate, or when speech, chewing and other functions are affected. It is required to have approval from your dentist and to not have any cavities or gum disease.	 Preapproval needed	Members under 21

The table above is not a full list of services that need preapproval or referral. If you have questions, please call Health Share Customer Service at Call 503-416-8090, or toll free at 888-519-3845 (TTY/TDD 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"), Health Share **only** provides dental benefits and free rides to dental appointments.

OHP and Health Share do not provide access to physical health or behavioral health services or free rides for these services.

If you have questions regarding coverage and what benefits are available, contact Customer Service at 503-416-8090, or toll free at 888-519-3845 (TTY/TDD 711).

Services that OHP pays for.

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

1. Services where you get Care Coordination from Health Share.
2. Services where you get Care Coordination from OHP.

Services with Health Share Care Coordination

Health Share still gives you Care Coordination for some services. Care Coordination means you will get free rides from Ride to Care for covered services, support activities and any resources you need for non-covered services.

Health Share will coordinate your care for the following services:

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

For more information or for a complete list about these services, call Customer Service at 503-416-8090, or toll free at 888-519-3845 (TTY/TDD 711).

Services that OHP pays for and provides Care Coordination.

OHP will coordinate your care for the following services:

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

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

You can still get a free ride from Ride to Care for any of these services. See page 92 for more information. Call Ride to Care at 503-416-3955 local 855-321-4899 toll-free TTY/TDD 711 to schedule a ride or ask questions.

Moral or religious objections.

Health Share does not limit services based on moral or religious objections.

If an individual provider refuses to provide services based on moral or religious objections, your health plan or Health Share will find a new provider to provide those services. Contact Health Share Customer Service with any questions at 503-416-8090, or toll free at 888-519-3845 (TTY/TDD 711).

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.

Health Share offers you a choice of five medical health plans. Each of those plans has a large network of providers, see page 39 for medical plan information. If the providers in your health plan cannot provide the services you need, you may be able to get services out-of-network. If the providers you want to see are not in your health plan's network, you can also switch health plans to choose from a different group of providers.

If you want to switch health plans, please contact Health Share Customer Service at 503-416-8090, or toll free at 888-519-3845 (TTY/TDD 711).

Your health plan 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 your area to meet your health care needs.

Your health plan keeps track of their network of providers to make sure they have the primary care and specialist care you need. They also make sure you have access to all covered services in your area.

Our health plans follow the state's rules about how far you may need to travel to see a provider. The rules are different based on the type of provider you need to see and the area you live in. For example, Primary Care Providers are "Tier 1", meaning your health plan needs to make sure you have a Primary Care Provider close to you. Providers in other "Tiers" might

be farther away, likea Dermatologist, who is "Tier 3." If you live in a remote area, it may take longer to get to a provider than if you live in an urban area.

The chart below lists the tiers of providers and how close to your home the different provider types need to be. This is based on your travel time (in minutes) or the distance (in miles) between where they are located and where you live.

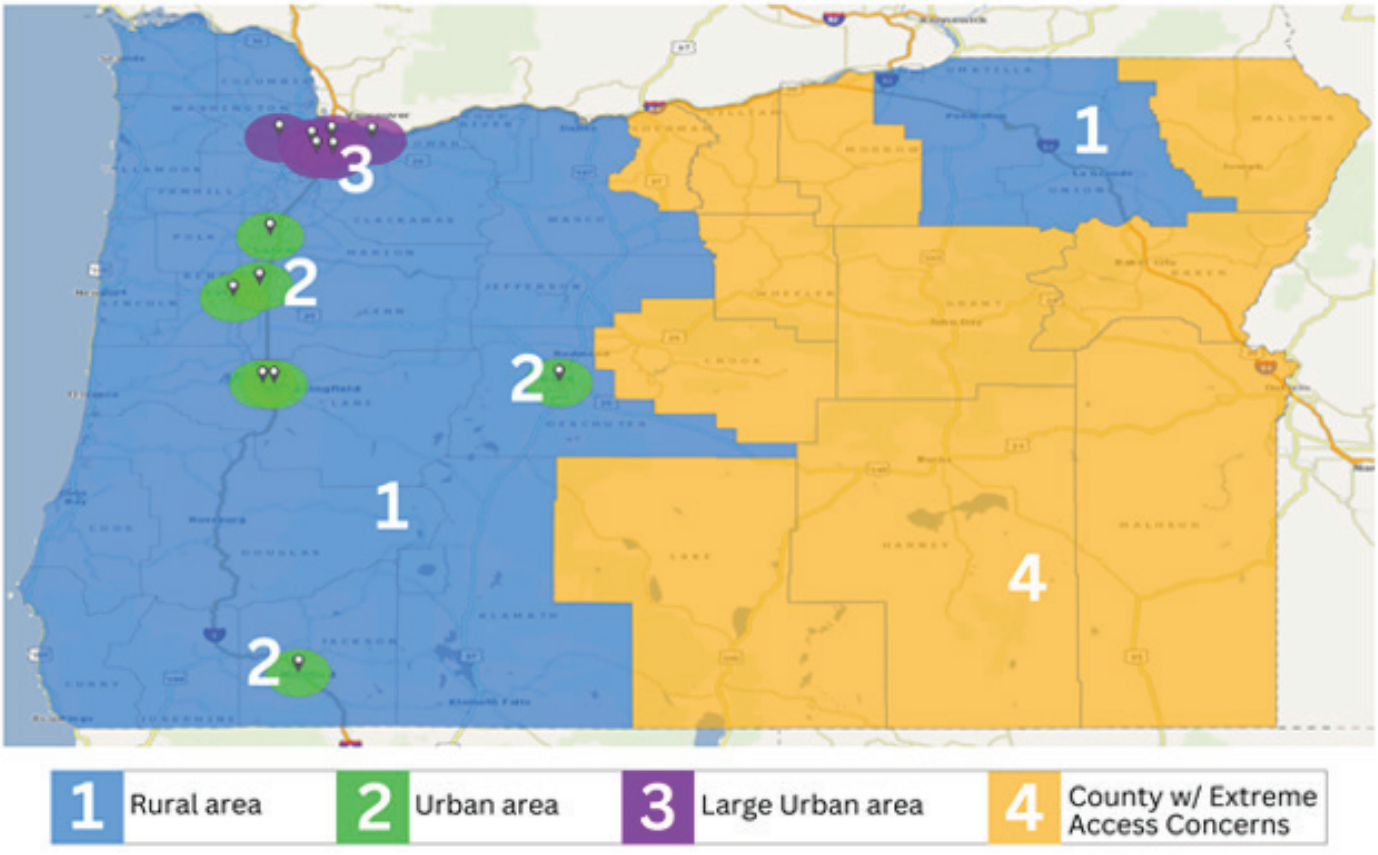
	Large Urban	Urban	Rural	County with Extreme Access Considerations
Tier 1	10 mins or 5 miles	25 mins or 15 miles	30 mins or 20 miles	40 mins or 30 miles
Tier 2	20 mins or 10 miles	30 mins or 20 miles	75 mins or 60 miles	95 mins or 85 miles
Tier 3	30 mins or 15 miles	45 mins or 30 miles	110 mins or 90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



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 Health Share at 503-416-8090 or toll free at 888-519-3845 (TTY/TDD 711) 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.

Care type	Timeframe
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.
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 503-416-8090, or toll free at 888-519-3845 (TTY/TDD 711).

Comprehensive and preventive benefits for members under age 21

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for OHP members from birth to age 21. This benefit provides you with the care you need for your health and development. These services can catch and help with concerns early, treat illness, and support children with disabilities.

You do not have to enroll separately in EPSDT; if you are under age 21 and enrolled in OHP you will receive these benefits.

The EPSDT benefit covers...

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

For members under age 21, Health Share must give:

- Regularly scheduled examinations and evaluations of physical, mental health, developmental, oral/dental health, growth, and nutritional status.
    - If your plan doesn't cover oral/dental health, you can still get these services through OHP by calling 1-800-273-0557.
- Starting January 1, 2023, all medically necessary and medically appropriate services must be covered for members under 21, regardless of whether it was covered in the past (this includes things that are "below the line" on the Prioritized List). To learn more about the Prioritized list, see page 48.

Under EPSDT, Health Share 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. Health Share may choose to cover the least expensive option that will work for you.

You should always receive a written notice when something is denied, and you have the right to an appeal if you don't agree with the decision. For more information, see page 152.

This includes *all* services:

- Physical Health
- Behavioral Health
- Dental Health
- Social Health Care Needs

If you or your family member needs EPSDT services, work with your Primary Care Provider (PCP) or talk to a care coordinator by calling 503-416-8090 or toll free at 888-519-3845 (TTY/TDD 711). They will help you get the care you need. If any services need approval, they will take care of it. Work with your Primary Care Dentist for any needed dental services. All EPSDT services are free.

Help getting EPSDT services.

- Call Customer Service at 503-416-8090 or toll free at 888-519-3845 (TTY/TDD 711)
- Call the dental plan listed on your ID card to set up dental services or for more information.
- You can free get rides to and from covered EPSDT provider visits. Call 503-416-3955 to set up a ride or for more information.
- You can also ask your PCP or visit our website at: https://www.healthshareoregon.org/members/my-health-plan/medical-benefits for a copy of the periodicity schedule. This schedule tells you when children need to see their PCP.

Screenings.

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

Screening visits include:

- Developmental screening.
- Lead testing:
    - Children must have blood lead screening tests at age 12 months and 24 months. Any child between ages 24 and 72 months with no record of a previous blood lead screening test must get one.

  - Completion of a risk assessment questionnaire does not meet the lead screening requirement for children in OHP. All children with lead poisoning can get follow up case management services.
- Other needed laboratory tests (such as anemia test, sickle cell test, and others) based on age and risk.
- Assessment of nutritional status.
- Overall unclothed physical exam with an inspection of teeth and gums.
- Full health and development history (including review of both physical and mental health development).
- Immunizations (shots) that meet medical standards:
  - Child Immunization Schedule (birth to 18 years): https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html
  - Adult Immunization Schedule (19+): https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html
- Health guidance and education for parents and children.
- Referrals for medically necessary physical and mental health treatment.
- Needed hearing and vision tests.
- And others.

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

EPSDT Referral, diagnosis, and treatment.

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

The screening provider will explain the need for the referral to the child and parent or guardian. If you agree with the referral, the provider will take care of the paperwork.

Health Share or OHP will also help with Care Coordination, as needed.

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

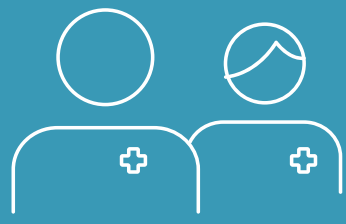
- Diagnosis of and treatment for impairments in vision and hearing, including eyeglasses and hearing aids.
- Dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health.
- Immunizations (if it is determined at the time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

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

- If we tell you that the service is not covered by OHP, you still have the right to challenge that decision by filing an appeal and asking for a hearing. See page 152.

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

For more information about EPSDT coverage, you can visit www.Oregon.gov/EPSDT. and view a member fact sheet. Health Share also has information at: https://www.healthshareoregon.org/members/my-health-plan/medical-benefits.



Traditional Health Workers (THW)

Traditional Health Workers (THW's) are trusted individuals from the community with similar life experiences to the members they work with. THW's help support both 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 helpful people and services in the community.

Health Share members do not need preapproval or a referral to work with Traditional Health Workers and all members are eligible for their services.

You can talk to your Primary Care Provider, your care coordinator or contact Health Share Customer Service at 503-416-8090, or toll free at 888-519-3845 (TTY/TDD 711) to learn more. You can also find up-to-date information on our website at: healthshareoregon.org/members/get-help, near the end of the page.

There are a few different kinds of Traditional Health Workers:

- **Birth Doula:** A person who helps people and their families with personal, non-medical support. They help through pregnancy, childbirth, and after the baby is born.
- **Community Health Worker:** A public health worker understands the people and community where you live. They help you access health and community services. A community health worker helps you start healthy behaviors. They usually share your ethnicity, language, or life experiences.

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

THW can help you with many things, like:

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

Extra services

Health-Related Services.

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

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

Flexible services.

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

Examples of flexible services your plan might offer include:

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

How to get flexible services for you or family member.

You can work with your provider to request flexible services, or you can call Customer Service at 888-519-3845 (TTY/TDD 711) and have a request form sent to you in the language or format that fits your needs.

Flexible services are not a covered benefit for members and CCOs are not required to provide them. Decisions to approve or deny flexible services requests are made on a case-by-case basis. If your flexible service request is denied, you will get a letter explaining your options. You can't appeal a denied flexible service, but you have the right to make a complaint. Learn more about appeals and complaints on page 152.

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

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

Community benefit initiatives.

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

Health Share offers many community benefit initiatives. Our community health improvement plan aims to improve access to care and food access. It also has a goal to provide supportive housing, improve chronic conditions and social connections.

Examples of other community benefit initiatives are:

- Classes for parent education and family support.
- Community-based programs that help families access fresh fruits and veggies through farmers markets.
- Active transportation improvements, such as safe bicycle lanes and sidewalks.

- School-based programs that support a nurturing environment to improve students' social-emotional health and academic learning.
- Training for teachers and child-specific community-based organizations on trauma informed practices.

Oral health community care.

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

You can learn more about All Smiles Community Oral Health at: www.allsmilescoh.org.

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

Open access points.

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

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

Health-Related Social Needs (HRSN)

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

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

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

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

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

You can ask to be screened for eligibility or to deny screening for eligibility. If approved, you can choose to receive or not receive HRSN Services. If approved, HRSN Services are free to you, and you can opt out at any time. If you receive HRSN Services, your Care Coordination team will work with you to make sure your care plan includes the services you receive. See page 44 for Care Coordination and care plans.

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

Free rides to care

Free rides to appointments for all Health Share members.

If you need help getting to an appointment, call Ride to Care for a free ride. You can get a free ride to any physical, dental, pharmacy, or behavioral health visit that is covered by Health Share.

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 can also pay you back for gas and mileage costs that you, a family member, or a friend spent to drive you to an appointment. There is no cost to you for this service. Health Share will never bill you for rides to or from covered services.

Schedule a ride.

Call Ride to Care at 503-416-3955 (TTY 711).

Hours: 9 a.m. to 5 p.m. Monday through Friday, except holidays. Holidays include New Year's Day (1/1/2024), Memorial Day (5/27/2024), Fourth of July (7/4/2024), Labor Day (8/2/2024), Thanksgiving (11/28/2024), and Christmas (12/25/2024).

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 Ride to Care.

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.

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

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

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

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

We will check to see if you are with Health Share 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 pickup. 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.

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

You can call the Ride to Care Monday through Friday, 8:00 a.m. to 5:00 p.m. Leave a message if you can't call during business hours. Call Ride to Care 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 Health Share if you do not agree with the denial. You have 60 days from the date of the denial notice to request an appeal. After the appeal, if the denial stands you also have the right to request a state hearing.

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

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

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

Learn more about complaints, grievances, appeals and hearings on page 152.

Rider guide.

Get the Ride to Care Rider Guide at: https://ridetocare.com. You or your representative can also call Customer Service at 503-416-3955 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

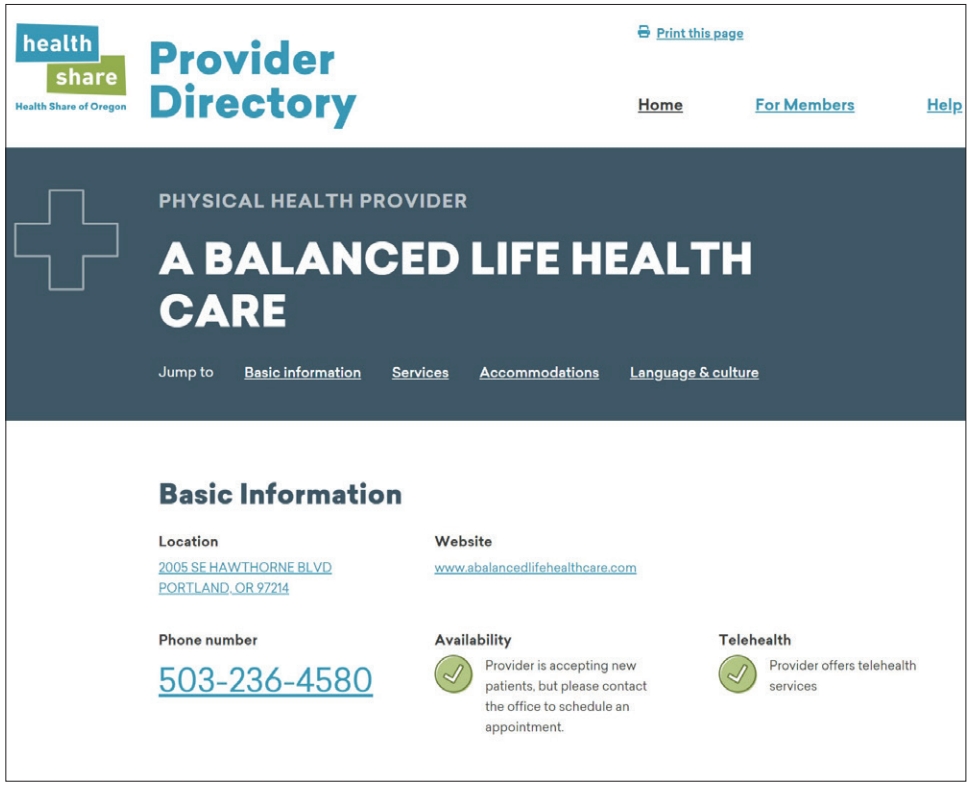
Telehealth (also known as telemedicine and tele-dentistry) is a way for you to get care without going into the clinic or office. Telehealth means you can have your appointment through a phone call or video call. Health Share will cover telehealth visits. Telehealth lets you visit your provider using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

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

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

How to find telehealth providers.

Not all providers have telehealth options. You should ask about telehealth when you call to make your appointment. You can also check our provider search tool at https://providers.healthshareoregon.org. When you search for a provider, click on the provider and it will bring you to a detailed page. This page will show if the provider offers telehealth services.



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

When to use telehealth.

Health Share members using telehealth have the right to get the physical, dental, and behavioral health services they need.

Some examples of when you can use telehealth are:

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

Telehealth is not recommended for emergencies. If you feel like your life is in danger, please call 911 or go to the nearest emergency room. You can get emergency care at any hospital, for a directory of network hospitals, see page 107.

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

Telehealth visits are private.

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

Learn more about privacy and the Health Insurance Portability and Accountability Act (HIPAA) on page 14.

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

You have a right to...

- Get telehealth services in the language you need.
- Have providers that respect your culture and language needs.
- Get qualified and certified interpretation services for you and your family. Learn more on page 5.
- Get in-person visits, not just telehealth visits.
    - Health Share 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.
    - Health Share will help identify what telehealth tool is best for you.

Talk to your provider about telehealth. You can also Customer Service at Call 503-416-8090 or toll free at 888-519-3845 (TTY/TDD 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 your medical health plan's network. You can find a list of pharmacies in your health plan's pharmacy directory, located at: https://www.healthshareoregon.org/members/my-health-plan/prescriptions. Click on the "Find a Pharmacy" link under your health plan.

If you need access to pharmacies not available through your current health plan, you can consider switching to a different health plan. Call Health Share Customer Service with questions or for help in switching plans at 888-519-3845 (TTY/TDD 711) or visit healthshareoregon.org.

You can look at the formularies (lists of covered drugs) for each of our health plans by using the links below. These links can also be found by clicking the "Prescription Drugs" link under each health plan at https://www.healthshareoregon.org/members/my-health-plan/prescriptions. If you have questions about the formulary, or which drugs are covered, please contact your medical health plan.

Kaiser Permanente	
Northwest Oregon Medicaid Formulary: healthy.kaiserpermanente.org/content/dam/kporg/final/documents/formularies/nw/medicaid-formulary-or-en-2023.pdf	Customer Service: 800-813-2000
Legacy Health PacificSource	
Find a drug: Medicaid | PacificSource: https://pacificsource.com/medicaid/find-a-drug	Customer Service: 877-500-2680
OHSU Health	
SavantRx DrugSearch: https://rx1-ext.rxtransaction.com/savantrx-drugsearch-url-web/?planid=bf97976c-dbd0-47d6-9e4c-78297bab3b92	Customer Service: 844-827-6572
Providence Health Assurance	
2023 Health Share of Oregon / Providence (OHP): https://php.adaptiverx.com/webSearch/index?key=cnhmbGV4LnBsY-W4uUGxhblBkZlR5cGUtMTc3MA==	Customer Service: 800-898-8174
CareOregon	
OHP Formulary - November 2023: careoregon.org/docs/default-source/providers/pharmacy-resources/formulary/careoregon-ohp-drug-formulary.pdf?sfvrsn=71bf531d_41	Customer Service: 800-224-4840

For all prescriptions covered by Health Share, bring to the pharmacy:

- The prescription.
- Your Health Share 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.

The list of covered medications Health Share is at: www.healthshareoregon.org/members/my-health-plan/prescriptions.

- If you are not sure if your medication is on our list, call us. We will check for you.
- If your medication is not on the list, tell your provider. Your provider can ask us to cover it.
- Health Share 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.

Health Share 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 Health Share to cover prescriptions.

When your provider asks your health plan to approve or cover a prescription:

- Doctors and pharmacists at your health plan will review the request from your provider.
- Your health plan will make a decision within 24 hours.
- If your health plan needs more information to make a decision, it can take 72 hours.

If your health plan decides to not cover the prescription, you will get a letter from them. The letter will explain:

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

If you decide to file an appeal, Health Share will work with your health plan to decide if the drug should be covered.

Call Health Share Pharmacy Customer Service at 503-416-8090 or toll free at 888-519-3845 (TTY/TDD 711) if you have questions.

Mail-order pharmacy.

Some medications can be mailed to your home address. This is called mail-order pharmacy. If picking up your prescription at a pharmacy is hard for you, mail-order pharmacy may be a good option. Health Share members can use a mail-order pharmacy. To learn more about mail-order pharmacy call Health Share Customer Service at 888-519-3845 (TTY 711). You can also learn more about mail-order pharmacies by visiting www.healthshareoregon.org/about/blog/your-prescription-medication-when-and-where-you-need-it.

OHP pays for behavioral health medications.

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

- Health Share and your provider will help you get the medications you need.
- The pharmacy sends your prescription bill directly to OHP. Health Share 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 Health Share Customer Service at 503-416-8090 or toll free at 888-519-3845 (TTY 711).

Prescription coverage for members with Medicare.

Health Share 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 Health Share ID card at the pharmacy.

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

Learn more about Medicare benefits on page 133.

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 Health Share at 503-416-8090 or toll free at 888-519-3845 (TTY/TDD 711) to find out if this is a good option for you.

Hospitals

Your providers will usually schedule non-emergency visits at hospitals inside your medical health plan's network, but Health Share members can get emergency care at any hospital. Here is a full list of the hospitals used by our five plans.

Adventist Health Portland
10123 SE Market St
Portland, OR 97216
503-257-2500 (TTY/TDD 711)
1-800-422-7871 (toll free)
http://www.adventisthealth.org/portland

Hillsboro Medical Center
335 SE 8th Ave
Hillsboro, OR 97123
503-681-1111 (TTY/TDD 711)
https://tuality.org/location/hospitals

Kaiser Sunnyside Medical Center
10180 SE Sunnyside Rd
Portland, OR 97015
800-813-2000 (TTY/TDD 711) (toll free)
https://healthy.kaiserpermanente.org/oregon-washington/facilities/sunnyside-medical-center-100249

Kaiser Permanente Westside Medical Center
2875 NE Stucki Ave
Hillsboro, OR 97124
800-813-2000 (TTY/TDD 711) (toll free)
https://healthy.kaiserpermanente.org/oregon-washington/facilities/kaiser-permanente-westside-medical-center-303481

Legacy Good Samaritan Medical Center
1015 NW 22nd Ave
Portland, OR 97210
503-413-7711
https://www.legacyhealth.org/Doctors-and-Locations/hospitals/legacy-good-samaritan-medical-center

Legacy Emanuel Medical Center
2801 N Gantenbein Ave
Portland, OR 97227
503-413-2200 (TTY/TDD 711)
https://www.legacyhealth.org/Doctors-and-Locations/hospitals/legacy-emanuel-medical-center

Legacy Meridian Park Medical Center
19300 SW 65th Ave
Tualatin, OR 97062
503-692-1212 (TTY/TDD 711)
https://www.legacyhealth.org/Doctors-and-Locations/hospitals/legacy-meridian-park-medical-center

Legacy Mt Hood Medical Center
24800 SE Stark St
Gresham, OR 97030
503-674-1122 (TTY/TDD 711)
https://www.legacyhealth.org/Doctors-and-Locations/hospitals/legacy-mount-hood-medical-center

Oregon Health & Science University (OHSU)
3181 SW Sam Jackson Park
Portland, OR 97239
503-494-8311 (TTY/TDD 711)
https://www.ohsu.edu/visit/ohsu-hospital-portland

OHSU Doernbecher Children's Hospital
700 SW Campus Drive
Portland, OR 97239
503-346-0640(TTY/TDD 711)
https://www.ohsu.edu/visit/doernbecher-childrens-hospital

Providence Milwaukie Hospital
10150 SE 32nd Ave
Milwaukie, OR 97222
503-513-8390 (TTY/TDD 711)
1-800-833-8899 (toll free)
https://www.providence.org/locations/or/milwaukie-hospital

Providence Portland Medical Center
4805 NE Glisan St
Portland, OR 97213
503-215-1111 (TTY/TDD 711)
1-833-386-1128 (toll free)
https://www.providence.org/locations/or/portland-medical-center

Providence St. Vincent Medical Center
9205 SW Barnes Rd
Portland, OR 97225
503-216-1234 (TTY/TDD 711)
1-888-550-1575 (toll free)
https://www.providence.org/locations/or/st-vincent-medical-center

Providence Willamette Falls Hospital
1500 Division St
Oregon City, OR 97045
503-656-1631 (TTY/TDD 711)
https://oregon.providence.org/location-directory/p/providence-willamette-falls-medical-center/

Randall Children's Hospital at Legacy Emanuel Medical Center
2801 N. Gantenbein Ave
Portland, OR 97227
503-276-6500 (TTY/TDD 711)
866-888-4398 (toll free)
https://www.legacyhealth.org/Doctors-and-Locations/hospitals/randall-childrens-hospital-at-legacy-emanuel

Shriners Hospitals for Children
3101 SW Sam Jackson Park Rd
Portland, OR 97239
503-241-5090 (TTY/TDD 711)
1-800-241-2155 (toll free)
https://www.shrinerschildrens.org/en/locations/portland

Unity Center for Behavioral Health
1225 NE 2nd Ave
Portland, OR 97232
503-944-8000 (TTY/TDD 711)
https://unityhealthcenter.org/

Vibra Specialty Hospital
10300 NE Hancock St
Portland, OR 97220
503-257-5500 (TTY/TDD 711)
https://vshportland.com/

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.

To learn which urgent care clinics are in your medical plan's network, visit our provider directory at: https://providers.healthshareoregon.org/find-a-provider/physical-health;

- Select your health plan under Supported networks
- Select "Group/Clinic": under Provider type
- Select "Urgent Care" under Specialty

You can also call your plan directly or call Health Share Customer Service at 503-416-8090 or toll free at 888-519-3845 (TTY 711).

CareOregon	800-224-4840
Kaiser Permanente	800-813-2000
Legacy Health PacificSource	877-500-2680
OHSU Health	844-827-6572
Providence Health Assurance	800-898-8174

For a list of all urgent care centers and walk-in clinics in Health Share's service area, see page 113.

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 Health Share 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 page 113 for a list of urgent care and walk-in clinics.

If you need help, call Health Share Customer Service at 503-416-8090, or toll free at 888-519-3845 (TTY/TDD 711).

If you have a dental emergency after hours call your dental plan or dental office. If the office is closed, the answering machine will relay your message to the on-call provider who will call you back. If you don't have a dentist, call your dental plan and they will help you. You can find your dental plan's provider directory online at www.healthshareoregon.org/members/my-health-plan/dental-benefits.

If following the steps above doesn't work, call 911 or go to the emergency room. See page 107 for a list of hospitals with emergency rooms.

After Hours Care (evenings, weekends, and holidays).

Your Primary Care Provider (PCP) looks after your care 24 hours a day, seven days a week. Even if the PCP's office is closed, call the clinic phone number. You

will speak to someone who will contact your PCP or give you advice on what to do. Sometimes your PCP may not be available. They will make sure another provider is always available to give you the care or advice you need. If your call is not answered when you call for afterhours care, leave a message and a representative will return your call.

Most medical plans have a different phone line for after-hours care. Your Medical Plan is listed on your Health Share ID Card.

CareOregon

If you're sick or injured and need after-hours advice, call your primary care clinic's regular phone number or your dental plan's number. The person who answers your call will either contact your doctor or a different doctor at the clinic or advise you on what to do.

Kaiser

For Kaiser members, a registered nurse is available by phone about any health concern 24/7 and has access to your health information. If you're unsure what kind of care you might need, call 1-800-813-2000.

Legacy Health PacificSource

You can speak with a registered nurse at any time, around the clock. They can answer common questions and guide you to appropriate care. Call 855-834-6150.

OHSU Health

Learn details about getting care in-person or virtually for minor illnesses and injuries, sprains and strains, rashes and more. For care, call 503-494-7551.

Providence Health Assurance

Providence Health Assurance members can call ProvRN around the clock to ask questions about their health. To use ProvRN have your member number available and call 503-574-6520 or 800-700-0481.

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

Urgent care centers and walk-in clinics in the Health Share area.

Network Urgent Care Centers and Walk-in Clinics in Washington, Multnomah, and Clackamas Counties. Call for operating hours.

AFC Urgent Care (Multiple Locations)

AFC Urgent Care – Beaverton
14278 SW Allen Blvd
Beaverton, OR 97005
Washington County
503-305-6262

AFC Urgent Care – NE
7033 NE Sandy Blvd
Portland, OR 97213
Multnomah County
503-305-6262

AFC Urgent Care – NW
25 NW 23rd Place, Ste. 11
Portland, OR 97210
Multnomah County
503-305-6262

Beaverton Medical and Dental Office - Kaiser
4855 SW Western Ave
Beaverton, OR 97005
Washington County
1-800-813-2000

Brave Care NE Portland
6924 NE Sandy Blvd
Portland, OR 97213
Multnomah County
503-963-7963

Care Essentials by Kaiser Permanente (Multiple Locations)

Care Essentials Hawthorne - Kaiser
3060 SE Hawthorne Blvd, Ste. 1
Portland, OR 97214
Multnomah County
855-235-0491

Care Essentials Pearl - Kaiser
1035 NW Northrup St
Portland, OR 97209
Multnomah County
855-235-0491

Clackamas County Urgent Mental Health Walk-in Clinic
11211 SE 82nd Ave, Ste. O
Happy Valley, OR 97086
Clackamas County
503-722-6200

Columbia Urgent Care Mall 205
9710 SE Washington St, Ste. B
Portland, OR 97216
Multnomah County
503-261-8000

Express Care OR LLC
4823 Meadows Rd, Ste. 127
Lake Oswego, OR 97035
Clackamas County
844-626-7768

Interstate Medical Office South - Kaiser
3500 N. Interstate Ave
Portland, OR 97227
Multnomah County
800-813-2000

Legacy Urgent Care Good Samaritan
Urgent Care Center
1015 NW 22nd Ave
Portland, OR 97210
Multnomah County
503-413-8026

Legacy GoHealth Clinic Cedar Hills
Urgent Care Center
2870 SW Cedar Hills Blvd
Beaverton, OR 97005
Washington County
503-646-9222

Legacy GoHealth Urgent Care Gresham
2850 SE Powell Valley Rd
Gresham, OR 97080
Multnomah County
503-666-5050

Legacy GoHealth Clinic Barbur
7461 SW Barbur Blvd, Ste B
Portland, OR 97219-2809
Multnomah County
971-202-2099

Legacy GoHealth Clinic Fairview
22262 NE Glisan St
Gresham, OR 97030-8553
Multnomah County
503-489-2024

Legacy GoHealth Clinic Johnson Creek
9361 SE 82nd Ave
Happy Valley, OR 97086
Clackamas County
971-202-2090

Legacy GoHealth Clinic Lake Oswego
3 Monroe Pkwy, Ste. X
Lake Oswego, OR 97035
Clackamas County
503-676-3748

Legacy GoHealth Clinic Lombard
1440 N Lombard St, Ste. B
Portland, OR 97217
Multnomah County
503-465-4875

Legacy GoHealth Clinic N Williams
3505 N Williams Ave
Portland, OR 97227-1437
Multnomah County
971-202-2910

Legacy GoHealth Clinic Oregon City
1900 McLoughlin Blvd, Ste. 127
Oregon City, OR 97045
Clackamas County
503-305-6159

Legacy GoHealth Clinic Pearl District
1244 NW Marshall St
Portland, OR 97209
Multnomah County
971-232-8620

Legacy GoHealth Clinic Raleigh Hills
4800 SW 76th Ave
Portland, OR 97225
Multnomah County
971-808-0665

Legacy GoHealth Clinic Sherwood
21430 SW Langer Farms Pkwy, Ste. 158
Sherwood, OR 97140
Washington County
971-808-0655

Legacy GoHealth Urgent Care West Linn
21900 Willamette Dr, Ste. 209
West Linn, OR 97068
Clackamas County
971-274-0038

Mt. Talbert Medical Office - Kaiser
10100 SE Sunnyside Rd
Clackamas, OR 97015
Clackamas County
503-813-2000

OHSU Health (Multiple Locations)

OHSU Family Medicine at Richmond Walk-in Clinic
4212 SE Division St, Ste. 150
Portland, OR 97206
Multnomah County
503-418-1500

OHSU Immediate Care Clinic, Richmond
4212 SE Division St, Ste. 150
Portland, OR 97206
Multnomah County
503-494-1700

OHSU Immediate Care Clinic, South Waterfront
3303 S Bond Avenue, ninth floor
Portland, Oregon 97239
Multnomah County
503-494-1700

Adventist Health Urgent Care – Parkrose, an OHSU Health partner clinic
1350 NE 122nd Ave, Ste. #200
Portland, OR 97230
Multnomah County
503-408-7008

Adventist Health Urgent Care – Sandy, an OHSU Health partner clinic
17055 Ruben Lane
Sandy, OR 97055
Clackamas County
503-668-8002

OHSU Immediate Care Clinic, Beaverton
15700 SW Greystone Ct
Beaverton, Oregon 97006
Washington County
503-494-1700

OHSU Health Immediate Care Clinic, Forest Grove, an OHSU Health partner clinic
1825 Maple Street
Forest Grove, OR 97116
Washington County
503-359-6180

OHSU Immediate Care Clinic, Scappoose
51377 Old Portland Road
Scappoose, Oregon 97056
Columbia County
503-494-1700

Outside In
1132 SW 13th Ave
Portland, OR 97203
Multnomah County
503-535-3860

PMG Immediate Care (Multiple Locations)

PMG Bridgeport Immediate Care
18040 SW Lower Boones Ferry Rd, Ste. 100
Tigard, OR 97224
Washington County
503-216-0700

PMG Canby Immediate Care
200 S Hazel Dell Way
Canby, OR 97013
Clackamas County
503-263-9500

PMG Gateway Immediate Care
1321 NE 99th Ave, Ste. 100
Portland, OR 97220
Multnomah County
503-215-9900

PMG Happy Valley Immediate Care
16180 SE Sunnyside Rd, Ste. 102
Happy Valley, OR 97015
Clackamas County
503-582-4900

PMG Scholls Immediate Care
12442 SW Scholls Ferry Rd, Ste. 100
Tigard, OR 97223
Clackamas County
503-215-9900

PMG Sherwood Immediate Care
16770 SW Edy Rd, Ste. 102
Sherwood, OR 97140
Washington County
503-216-9600

PMG Tanasbourne Immediate Care
10670 NE Cornell Rd, Ste. 101
Hillsboro, OR 97124
Washington County
503-216-9360

Tuality Medical Group (Multiple Locations)

Tuality Medical Group - Hillsboro
7545 SE Tualatin Valley Hwy
Hillsboro, OR 97123
Washington County
503-681-4223

Tuality Medical Group – Forest Grove
1809 Maple St
Forest Grove, OR 97116
Washington County
503-359-6180

Tuality Physicians Group
900 SE Oak St, Ste. 202
Hillsboro, OR 97123
Washington County
503-640-3724

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 Health Share Customer Service at 888-519-3845. 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 are 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 Health Share Customer Service within 3 days of receiving emergency care.
- You have a right to use any hospital or other setting, within the United States.
- An emergency is covered in the United States. It is not covered in Mexico or Canada.

- Emergency care provides post stabilization (after care) services. After care services are covered services related to an emergency condition. These services are given to you after you are stabilized. They help to maintain your stabilized condition. They help to improve or fix your condition.

You can get emergency care at any hospital, for a directory of network hospitals, see page 107.

Dental emergencies.

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

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

For a dental emergency, please call your Primary Care Dentist (PCD). You will be seen within 24 hours. Some offices have emergency walk-in times. If you cannot reach your PCD or you do not have one, call Customer Service at 503-416-8090, or toll free at 888-519-3845 (TTY/TDD 711). They will help you find emergency dental care.

If none of these options work for you, call 911 or visit the Emergency Room. **If you need an ambulance ride, please call 911.** You can get emergency care at any hospital, for a directory of network hospitals, see page 107.

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. Health Share 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.

Clackamas County: 503-655-8585
Multnomah County: 503-988-4888
Washington County: 503-291-9111

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.

Or visit the following locations for urgent mental health treatment:

Unity Center for Behavioral Health – Psychiatric Emergency Service (Lloyd District Area)
Open 24/7
1225 NE 2nd Ave
Portland, OR 97232
503-944-8000

Cascadia Urgent Mental health Walk-in Center (Multnomah County/ SE Richmond Area)
Open 7 days a week from 7 a.m. – 10:30 p.m.
4212 SE Division, Ste. 100
Portland, OR 97206
503-963-2575

Clackamas County Urgent Mental Health Walk-in (Happy Valley)
Clinic open Monday – Friday, 9 a.m. to 7 p.m., Weekends 10 a.m. – 7 p.m.
11211 SE 82nd Ave, Ste. O
Happy Valley, OR 97086
503-742-5335

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 Health Share can do to support stabilization in the community:

- A crisis hotline to call when a member needs help.
- Mobile crisis team that will come to a member who needs help.
- Walk-in and drop-off crisis centers (see locations on page 121).
- 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, which are provided after the emergency is stabilized and to maintain stabilization or resolve the condition.

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

See more about behavioral health services offered on page 64.

Suicide prevention.

If you are struggling, it is okay to share your feelings and reach out for help. If you or someone you know is having suicidal thoughts, it is important to get professional mental health support. Talking with someone about your thoughts and feelings can save your life.

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!

Follow-up care after an emergency.

After an emergency, you may need follow-up care. This includes anything you need after leaving the emergency room. Follow-up care is not an emergency. OHP does not cover follow-up care when you are out of state. Call your Primary Care Provider or Primary Care Dentist office to set up any follow-up care.

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

Care away from home

Planned care out of state.

Health Share 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.

Emergency care away from home.

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

Do not pay for emergency care. If you pay the emergency room bill, Health Share is not allowed to pay you back. See page 127 or what to do if you get billed.

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

1. Make sure you have your Oregon Health ID Card and Health Share ID card with you when you travel out of state.
2. Show them your Health Share ID Card and ask them to bill Health Share.
3. Do not sign any paperwork until you know the provider will bill Health Share. Sometimes Health Share cannot pay your bill if an agreement to pay form has been signed. To learn more about this form see page 127.
4. You can ask the Emergency Room or provider's billing office to contact Health Share 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 Health Share for help.

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

Bills for services

OHP members do not pay bills for covered services.

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

No Health Share in-network provider (for a list of in-network providers see page 38) 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 Health Share for services you are not responsible for to the contracted provider.

Members cannot be billed for missed appointments or errors.

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

Members cannot get balance or surprise billing.

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

If you have questions, call Customer Service 503-416-8090 or toll free at 888-519-3845 (TTY/TDD 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 Health Share for help right away at 503-416-8090 or toll free at 888-519-3845 (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 Health Share, 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 Health Share to see if a treatment or services is not covered. If you chose to get a service that is not covered, you may have to pay the bill.

You have to pay the provider if:

- **You get routine care outside of Oregon.** You get services outside Oregon that are not for urgent or emergency care.
- **You don't tell the provider you have OHP.** You did not tell the provider that you have Health Share, another insurance or gave a name that did not match the one on the Health Share ID at the time of or after the service was provided, so the provider could not bill Health Share. Providers must verify your Health Share eligibility at the time of service and before billing or doing collections. They must try to get coverage info prior to billing you.

- **You continue to get a denied service.** You or your representative requested continuation of benefits during an appeal and contested case hearing process, and the final decision was not in your favor. You will have to pay for any charges incurred for the denied services on or after the effective date on the notice of action or notice of appeal resolution.
- **You get money for services from an accident.** If a third-party payer, like car insurance, sent checks to you for services you got from your provider and you did not use these checks to pay the provider.
- **We don't work with that provider.** When you choose to see a provider that is not in-network with Health Share you may have to pay for your services. Before you see a provider that is not in-network with Health Share you should call Customer Service or work with your PCP. Prior approval may be needed or there may be a provider in-network that can fit your needs. For a list of in-network Providers see page 38.
- **You choose to get services that are not covered.** You must pay when you choose to have services that the provider tells you are not covered by Health Share. 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 Health Share Customer Service first to discuss what is covered. If you get a bill, please contact Health Share 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 Health Share Customer Service at 503-416-8090 or toll free at 888-519-3845 (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 Health Share or OHP. The form is also called a waiver. You can see a copy of the form at https://bit.ly/OHPwaiver.

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

- The form must have the estimated cost of the service. This must be the same as on the bill.
- The service is scheduled within 30 days from the date you signed the form.
- The form says that OHP does not cover the service.
- The form says you agree to pay the bill yourself.
- You asked to privately pay for a covered service. If you choose to do this, the provider may bill you if they tell you in advance the following:
    - The service is covered and Health Share would pay them in full for the covered service.
    - The estimated cost, including all related charges, the amount Health Share would pay for the service. The provider cannot bill you for an amount more than Health Share 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 Health Share for the covered service listed on the agreement.

Bills for emergency care away from home or out of state.

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

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

- Do not ignore medical bills.
- Contact Health Share Customer Service as soon as possible at 503-416-8090 or toll free at 888-519-3845 (TTY 711).
  Hours: Monday through Friday 8:00 a.m. – 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 Health Share, contact Customer Service. Learn more about denials, your right to an appeal, and what to do if you disagree with us on page 152.
  - You can also appeal by sending Health Share 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 Health Share.
- Health Share pays for all covered services in accordance with the Prioritized List of Health Services, see page 48.
- For a brief list of benefits and services that are covered under your OHP benefits with Health Share, who also covers case management and Care Coordination, see page 44. If you have any questions about what is covered, you can ask your PCP or call Health Share customer service.
- No Health Share 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 Health Share for services you are not responsible for.
- Members are never charged for rides to covered appointments. See page 92. 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 Health Share or your provider tell you that the service is not covered by OHP, you still have the right to challenge that decision by filing an appeal and asking for a hearing. See page 152.
- In the event of Health Share 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.

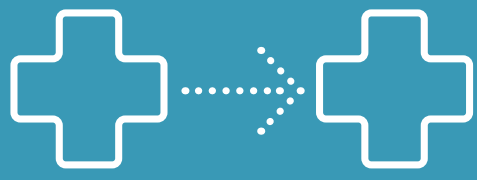
Call Customer Service to learn more about which benefits are paid for by Medicare and OHP (Medicaid), or to get help finding a provider and how to get services.

Providers will bill your Medicare and Health Share.

Health Share 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 Health Share. If they still say you owe money, call Customer Service at 503-416-8090 or toll free at 888-519-3845 (TTY 711). We can help you.
- Learn about the few times a provider can send you a bill on page 128.

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



Changing CCOs and moving care

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

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

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

Members with Medicare and OHP (Medicaid) .

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

American Indian and Alaska Native with proof of Indian Heritage.

Members who want to get care somewhere else. They can get care from an Indian Health Services facility, tribal health clinic/program, or urban clinic and OHP fee-for-service.

Service areas with only one CCO.

Members with only one CCO in their service area may ask to disenroll (leave) a CCO and get care from OHP fee-for-service at any time for any of the following "with cause" reasons:

- The CCO has moral or religious objects about the service you want.
- You have a medical reason. When related services are not available in network and your provider says that getting the services separately would mean unnecessary risk. Example: a Caesarean section and a tubal ligation at the same time.
- Other reasons including, but not limited to, poor care, lack of access to covered services, or lack of access to network providers who are experienced in your specific health care needs.
- Services are not provided in your preferred language.
- Services are not provided in a culturally appropriate manner; or
- You're at risk of having a lack of continued care.

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

Service areas with more than one CCO.

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

- You move out of the service area.
    - If you move to a place that your CCO does not serve, you can change plans as soon as you tell OHP about the move. Please call OHP at 800-699-9075 or use your online account at ONE.Oregon.gov.
- The CCO has moral or religious objections about the service you want.
- You have a medical reason. When related services are not available in network and your provider says that getting the services separately would mean unnecessary risk. Example: a Caesarean section and a tubal ligation at the same time.
- Other reasons including, but not limited to, poor care, lack of access to covered services, or lack of access to network providers who are experienced in your specific health care needs.
- Services are not provided in your preferred language.
- Services are not provided in a culturally appropriate manner; or you're at risk of having a lack of continued care.

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

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

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

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

How to change or leave your CCO.

Things to consider: Health Share wants to make sure you receive the best possible care. Health Share 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 Health Share.

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

Tell OHP if you want to change or leave your CCO. You and/or your representative can call OHP Customer Service at 800-699-9075 or 800-273-0557 (TTY 711) from Monday through Friday, 8 a.m. to 5 p.m. PT. Use your online account at ONE.Oregon.gov or email OHP at Oregon.Benefits@odhsoha.oregon.gov.

You can get care while you change your CCO. See page 140 to learn more.

Health Share can ask you to leave for some reasons.

Health Share may ask OHA to remove you from our plan if you:

- Are abusive, uncooperative, or disruptive to our staff or providers. Unless 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 Health Share staff. When the act or threat of violence seriously impairs Health Share's ability to furnish services to either you or other members.

We must ask the state (Oregon Health Authority) to review and approve removing you from our plan. You will get a letter if our request to disenroll (remove) you has been approved. You can make a complaint if you are not happy with the process or if you disagree with the decision. See page 152 for how to make a complaint or ask for an appeal.

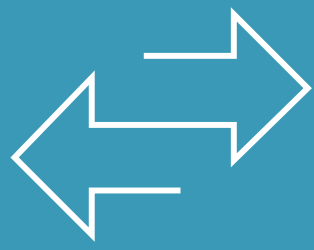
Health Share cannot ask to remove you from our plan because of reasons related to (but not limited to):

- 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 Health Share disagrees with.

For more information or questions about other reasons you may be disenrolled, temporary enrollment exceptions or enrollment exemptions, call Health Share at 503-416-8090 or toll free at 888-519-3845 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:

- Members who need end-stage renal disease care.
- Medically fragile children.
- Members receiving breast and/or cervical cancer treatment.
- Members getting CAREAssist help due to HIV/AIDS.

- Members who had a transplant.
- Members who are pregnant or just had a baby.
- Members 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 Health Share, we will work with your new CCO or OHP to make sure you can get those same services listed on the next page.

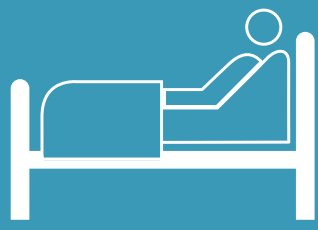
If you need care while you change plans or have questions, please call Health Share Customer Service at: 503-416-8090 or toll free at 888-519-3845 (TTY users, call 711)
Hours: Monday through Friday, 8 a.m. to 5 p.m. PST

Health Share 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 Health Share 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, a qualified provider will review the treatment plan.
- 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 Health Share Transition of Care Policy by calling Customer Service at 503-416-8090 or toll free at 888-519-3845. It is also on our website on the Transition of Care page near the end of the page at www.healthshareoregon.org/members/get-help/transition-of-care-2. 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**.

Learn more about Advance Directives through your health plan.

CareOregon
You can get and Advance Directive form at no cost by calling CareOregon Customer Service at 800-224-4840 TTY 711. You can also get it from Oregon Health Decisions by calling toll-free 800-422-4805.
Kaiser Permanente
Visit: https://healthy.kaiserpermanente.org/oregon-washington/health-wellness/life-care-plan/advance-health-care-directive
Legacy Health PacificSource
Visit: https://www.legacyhealth.org/patients-and-visitors/about-your-care/your-hospital-stay/checking-in/advance-directive-and-POLST
OHSU Health
Visit: www.ohsu.edu/health/instructions-filling-out-advance-directives

Providence Health Assurance
Visit: https://www.providencehealthplan.com/health-share-providence-ohp/advanced-directives-and-declaration-for-mental-health-treatment

An Advance Directive allows you to:

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

How to get more information about Advance Directives.

To view Health Share's Advanced Directives and Declaration for Mental Health Treatment Policy, visit: https://www.healthshareoregon.org/advanced-directives-policy. You may also call Health Share customer service to request a paper copy be sent to you.

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

How to complain if Health Share did not follow Advance Directive requirements.

You can make a complaint to the Health Care Regulation and Quality Improvement Office of Community Health and Health Planning if your provider does not do what you ask in your Advance Directive.

Call Health Share Customer Service at Call 503-416-8090 or toll free at 888-519-3845 (TTY/TDD 711) to get a paper copy of the complaint form.

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

Health Care Regulation and Quality Improvement
Office of Community Health and Health Planning
Oregon Health Authority
800 NE Oregon Street, Suite 465
Portland, OR 97232
971-673-0540; fax 971-673-0556

How to cancel an Advance Directive.

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

What is the difference between a POLST and Advance Directive?

Portable Orders for Life-Sustaining Treatment (POLST).

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

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

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

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

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, allowing only a court and two doctors to make decisions about your mental health if you cannot.

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

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

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

If your provider does not follow your wishes in your form, you can complain. A form for this is at www.healthoregon.org/hcrqi. Send your complaint to:

Health Care Regulation and Quality Improvement
800 NE 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 Health Share takes this seriously.

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

- A provider charging you for a service covered by Health Share.
- 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.

Health Share 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 Health Share. **We report all suspected fraud, waste, and abuse committed by providers or members to the state agencies listed below.**

Call our compliance hotline:

503-416-1459 (TTY/TDD 711)
Fax: 503-459-5749
Website: https://www.oregon.gov/oha/FOD/PIAU/Pages/Report-Fraud.aspx
Write to: Health Share
ATTN: Compliance
2121 SW Broadway, Ste. 200
Portland, OR 97201

—OR—

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

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

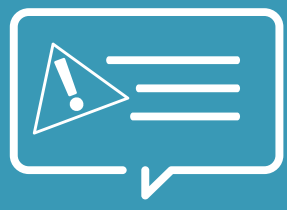
—OR (specific to providers)—

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

—OR—

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

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



Complaints, grievances, appeals and fair hearings

Health Share tries to make it easy for members to file a complaint, grievance, or appeal or to schedule a hearing with the Oregon Health Authority.

Health Share can 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:

Email: info@healthshareoregon.org
Mail: Civil Rights Manager
2121 SW Broadway, Ste. 200
Portland, OR 97201
Phone: 503-416-1459 (TTY/TDD 711)
Fax: 503-459-5749

You may also visit our website at: https://www.healthshareoregon.org/members/get-help/member-rights/appeals-and-grievances.

Learn more about Advance Directives and get access to important forms through these links from our health plans.

CareOregon
https://www.careoregon.org/members/benefits-overview/lists/benefits-topics/2f180000-9f66-4741-b470-d65014ffc831
Kaiser Permanente
Visit: https://healthy.kaiserpermanente.org/oregon-washington/support/submit-a-complaint#/tellus
Legacy Health PacificSource
Visit: https://pacificsource.com/medicaid/your-plan/complaints-and-appeals
OHSU Health
Visit: https://www.ohsu.edu/health/patient-complaint-process
Providence Health Assurance
Visit: https://www.providencehealthplan.com/health-share-providence-ohp/complaints-and-appeals
Ride to Care
Visit: http://ridetocare.com

You can make a complaint.

- A **complaint** is letting Health Share or one of our plan partners know you are not satisfied.
- A **dispute** is when you do not agree with Health Share, a plan partner or a provider.
- A **grievance** is a complaint you can make if you are not happy with Health Share, a plan partner, 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 503-416-8090 or toll free at 888-519-3845 (TTY/TDD 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:
Civil Rights Manager
2121 SW Broadway, Ste. 200
Portland, OR 97201

You may also find a complaint form at www.healthshareoregon.org/members/get-help/member-rights/appeals-and-grievances.

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

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, Health Share, or Health Share's plan partners.
- Care you were not sure about but got anyway.
- Bills for services you did not agree to pay.
- 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.

Health Share, 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 asks for an expedited result or supports a member's appeal.
- Encourage the withdrawal of a complaint, appeal, or hearing already filed.
- Use the filing or result of a complaint, appeal, or hearing as a reason to react against a member or to request member disenrollment.

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

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

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

If you disagree with our decision, you have the right to ask us to change it. This is called an appeal because you are appealing our decision.

To support your appeal, you have the right to:

* Give information 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 on next page.

Don't agree with our decision?

Follow these steps.

1. **Ask for an appeal.** You must ask within 60 days of your denial letter's date. Call or send a form.
2. **Wait for our reply.** We have 16 days to reply. Need a faster reply? Ask for a fast appeal.
3. **Read our decision.** Still don't agree? You can call 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 503-416-8090 or toll free at 888-519-3845 (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: Health Share of Oregon Grievance Department 2121 SW Broadway, Ste. 200 Portland, OR 97201 You can also fax the form or written request to 503-459-5749. **Who can ask for an appeal?** You or someone with written permission to speak for you. That could be your doctor or an authorized representative.

Step 2	**Wait for our reply.**

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

How long do you get to review my appeal?

We have 16 days to review your request and reply. If we need more time, we will send you a letter. We have up to 14 more days to reply.

What if I need a faster reply?

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

How long does a fast appeal take?

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

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

If a fast appeal is denied or more time is needed, we will call you and you will receive written notice within two days. A denied fast appeal request will become a standard appeal and needs to be resolved in 16 days or possibly be extended 14 more days.

If you don't agree with a decision to extend the appeal time frame or if a fast appeal is denied, you have the right to file a complaint.

Step 3	**Read our decision.** We will send you a letter with our appeal decision. This appeal decision letter is also called a Notice of Appeal Resolution (NOAR). If you agree with the decision, you do not have to do anything.
Step 4	**Still don't agree? Ask for a hearing.** You can ask the state to review the appeal decision. This is called asking for a hearing. You must ask for a hearing within 120 days of the date of the appeal decision letter (NOAR). **What if I need a faster hearing?** You can ask for a fast hearing. This is also called an expedited hearing. Use the online hearing form at 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 must get a denial letter before you can ask for an appeal.

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

What if Health Share doesn't meet the appeal timeline?

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

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

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

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

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

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

You need to:

- Ask for this within 10 days of the date of notice or by the date this decision is effective, whichever is later.
- You can call us 503-416-8090 or toll free at 888-519-3845 at (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.**

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 Health Share and Medicare, you may have more appeal rights than those listed above. Call Customer Service at 503-416-8090 or toll free at 888-519-3845 (TTY 711) for more information. You can also call Medicare at 1-800-633-4227 to find out more on your appeal rights.

What if I want to see the records that were used to make the decision about my service(s)?

You can contact Health Share at 503-416-8090 or toll free at 888-519-3845 (TTY 711) to ask for free copies of all paperwork used to make the decision.

Words to know

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Emergency medical condition – An illness or injury that needs care right away. This can be bleeding that won't stop, severe pain or broken bones. It can be something that will cause

some part of your body to stop working. An emergency mental health condition is the feeling of being out of control or feeling like you might hurt yourself or someone else.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Out-of-network provider – A provider who has not signed a contract with the CCO. The CCO doesn't pay for members to see them. You must 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.

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

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

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

Premium – The cost of insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

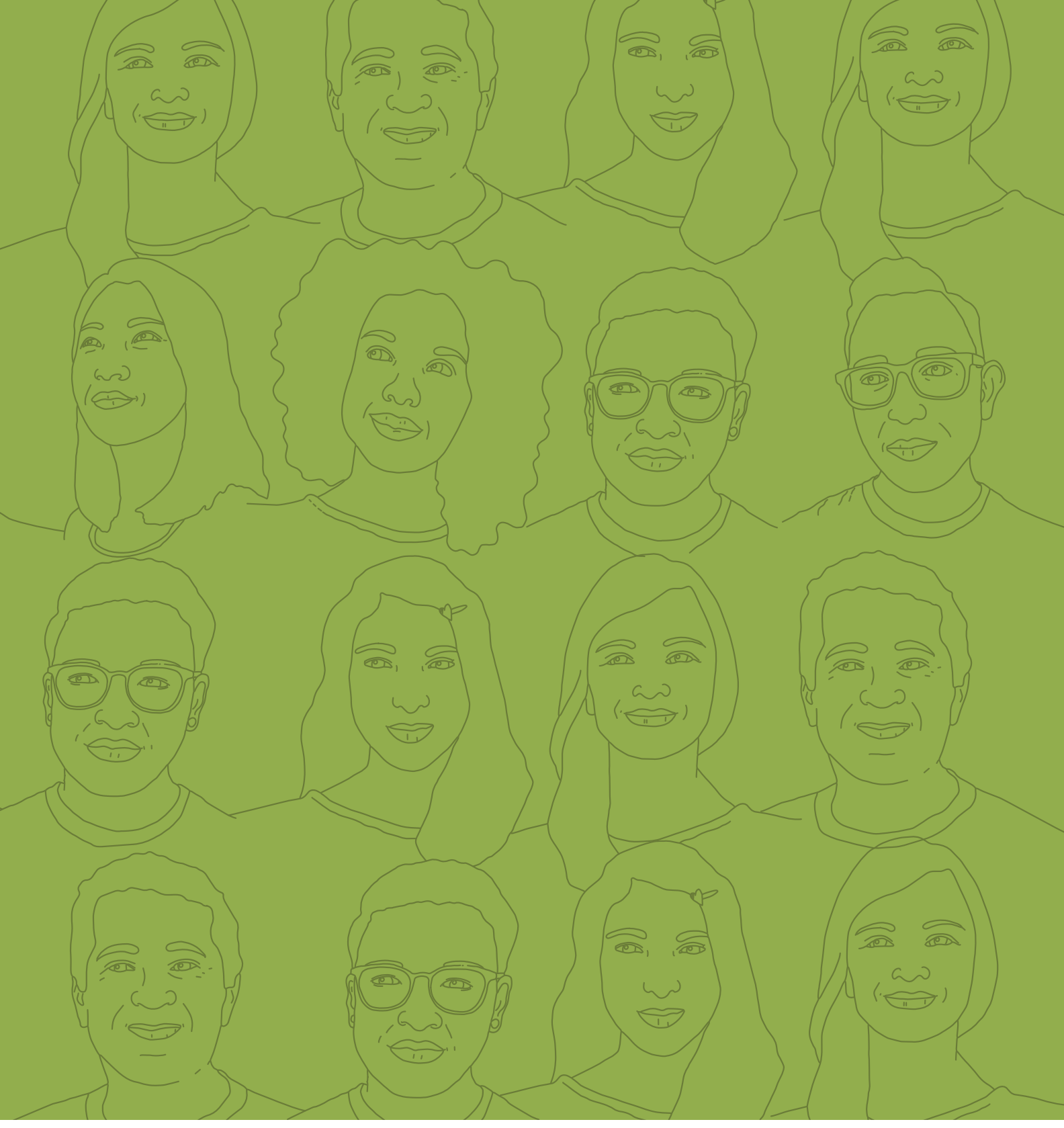
Transition of care – Some members who change OHP plans can still get the same services and see the same providers. That means care will not change when you switch CCO plans or move to/from OHP fee-for-service. This is called transition of care. If you have serious health issues, your new and old plans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



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Health Share of Oregon

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