

Simplified Chart of OHP Coverage of Dental Services

Please see OAR 410-123-1000 through 1670 for details

(November 19, 2013)

Service	OHP Plus Child	OHP Plus Pregnant Adults	Non-pregnant OHP Plus Adults
Exams (D0120-D0180)	2 times every 12 months	1 time every 12 months	1 time every 12 months
Imaging (D0210-D0395)	Yearly routine and bitewings; panoramic and complete series every 5 years; more if medically/dentally appropriate		
Prophylaxis (D1110-D1120)	2 times every 12 months (more if "high risk")	1 time every 12 months (more if "high risk")	
Fluoride (D1204-D1208)	2 times every 12 months, plus additional (up to 4 if "high risk")	1 time every 12 months (up to 4 if "high risk")	
Sealant (D1351)	1 treatment per permanent molar every 5 years (unless failure)	Not covered	Not covered
Space maintainers (D1510-D1555)	Covered	Not covered	Not covered
Amalgam and Resin-Based Composite Restorations (D2140-D2394)	Amalgam only for posterior 2+ surfaces; otherwise amalgam and resin covered (i.e. cover D2140 – D2391)		
Crowns (D2390-D2752)	Covered	Covered	Not covered
Endodontic Therapy (D3230-D3330)	Covered (on primary, anterior, bicuspid, and 1st/2nd molars)	Covered (on anterior, bicuspid and only 1st molar)	Covered (on anterior and bicuspid)
Endodontic Retreatment (D3346-D3354)	Covered for symptomatic anterior	Covered for symptomatic anterior	Covered for symptomatic anterior
Scaling and Root Planing (D4341-D4342)	1 time every 2 years	1 time every 3 years, plus more if necessary	1 time every 3 years
Full Mouth Debridement (D4355)	1 time every 2 years	1 time every 3 years	1 time every 3 years
Periodontal Maintenance (D4910)	1 time every 6 months, more if medically/dentally necessary	1 time every 12 months, more if medically/dentally necessary	1 time every 12 months, more if medically/dentally necessary
Full Dentures (D5110-D5140)	Covered	Covered if recently edentulous	Covered if recently edentulous

Service	OHP Plus Child	OHP Plus Pregnant Adults	Non-pregnant OHP Plus Adults
Partial Dentures (D5211-D5212)	Covered if 1+ missing anterior or 4+ missing posterior per arch	Covered if 1+ missing anterior or 6+ missing posterior per arch	
Replacement of Full or Partial Dentures (D5110-D5212)	1 time every 10 years	No replacement of full dentures, partial dentures 1 time every 10 years	No replacement of full dentures, partial dentures 1 time every 10 years
Denture Adjustment and Repairs (D5410-D5671)	Covered w/no limits	Covered, with limits	Covered, with limits
Denture Rebases (D5710-D5721)	1 time every 3 years	1 time every 5 years	1 time every 5 years
Denture Relines (D5730-D5761)	1 time every 3 years	1 time every 5 years	1 time every 5 years
Interim Partial Denture (D5820-D5821)	Covered, must have 1 or more missing anterior, replacement 1 time every 5 years		
Extractions (D7111-D7251)	Covered	Covered	Covered
Alveoplasty not in Conjunction with Extractions (D7320-D7321)	Covered	Covered	Not covered
Frenulectomy, Frenulosplasty (D7960, D7963)	1 time per lifetime per arch	Not covered	Not covered
Excision of Periocoronary Gingival (D7971)	Covered	Covered	Not covered
Orthodontics (D8000-D8999)	Covered if cleft palate	Not covered	Not covered

Simplified Chart of OHP Coverage of Dental Services

Though a service may be covered (✓), there may be limitations on frequency or tooth. This chart lists some but not all of these limits. This chart is only a general guide that is intended to give a snapshot of coverage. Please see OAR 410-123-1000 to 1670 for details.

Service	OHP Plus Child	OHP Plus Adult	OHP Plus Supplemental (for pregnant adults)
Comprehensive Dental Exam	✓ twice a year	✓ once a year	✓ once a year
X-rays	✓	✓	✓
Routine Cleanings	✓	✓	✓
Professionally-Applied Fluoride	✓ twice a year or up to 4 if “high risk”	✓ once a year or up to 4 if “high risk”	✓ once a year or up to 4 if “high risk”
Sealants	✓	X	X
Fillings	✓	✓	✓
Crowns	✓	X	✓
Root Canals	✓ anterior teeth and bicuspid	✓ anterior teeth and bicuspid	✓ anterior teeth and bicuspid
	✓ 1 st molars	X 1 st molars	✓ 1 st molars
	✓ 2 nd molars	X 2 nd molars	X 2 nd molars
Scaling and Root Planing (a periodontal disease treatment)	✓ once every 2 years	✓ once every 3 years	✓ once every 3 years, plus more if necessary
Extractions	✓	✓	✓
Orthodontics	Only covered in cases of cleft palate	X	X

Hospital Dentistry	<ul style="list-style-type: none"> ✓ kids ≤ 3 with extensive dental needs ✓ kids age 4+ who meet at least one criterion (ex. extensive dental trauma, failed attempt to treat in office with nitrous, developmental disability with acute situational anxiety and extreme uncooperative behavior) 	<ul style="list-style-type: none"> ✓ for adults who meet at least one criterion. The criteria for adults are somewhat more restrictive, generally requiring extensive dental trauma or a need for hospitalization due to severe disability. 	<ul style="list-style-type: none"> ✓ for adults who meet at least one criterion. The criteria for adults are somewhat more restrictive, generally requiring extensive dental trauma or a need for hospitalization due to severe disability.
First Full Upper or Lower Denture	✓ (age 16-21)	✓ only if last tooth in the jaw was removed within last 6 months	✓ only if last tooth in the jaw was removed within last 6 months
First Partial Upper or Lower Denture	✓ if missing 1+ front or 4+ back teeth, wisdom teeth don't count	✓ only if missing 1+ front or 6+ back teeth, and wisdom teeth don't count	✓ only if missing 1+ front or 6+ back teeth, and wisdom teeth don't count
Replace Partial Denture	✓ once every 10 years if needed	✓ once every 10 years if needed	✓ once every 10 years if needed
Replace Full Denture	✓	X	X
Denture Adjustments, Repairs, Rebases, and Relines	✓ (with substantial frequency limits)	✓ (with substantial frequency limits)	✓ (with substantial frequency limits)
Interim Partial Denture ("Flipper")	✓ if missing 1+ front teeth; replacement every 5 years	✓ if missing 1+ front teeth; replacement every 5 years	✓ if missing 1+ front teeth; replacement every 5 years

CAWEM (Citizen/Alien-Waived Emergency Medicaid) is a Medicaid program for clients who would be eligible for OHP but do not meet the citizenship and immigration requirements. There are two benefit packages:

- **CAWEM Standard:** dental coverage is limited to services provided in an emergency department hospital setting.
- **CAWEM Plus:** must be pregnant; dental coverage is equivalent to OHP Plus Supplemental for pregnant adults.

Oregon Health Plan Client Handbook



Department of Human Services



July 2007

This booklet contains important information about your OHP

Benefit packages:

- Premiums
- Copayments

Covered services:

- Medical
- Dental
- Mental health

Medical Care ID

Service Delivery:

- Fee-for-Service
- Managed Care

Rights and responsibilities

Client resources



July 1, 2013

Update your OHP Client Handbook

If you need help to update your handbook or need a different format or language, please ask your worker or call 1-800-699-9075.

Page 2: Prioritized List of Health Services

- The Oregon Health Evidence Review Commission now updates this list.

Page 3: OHP Plus and OHP with Limited Drug vision benefit reduced

- Non-pregnant adults age 21 years or older do not receive routine vision testing and eyeglasses.
- Pregnant adults age 21 years or older receive these services as part of the OHP Plus Supplemental benefit package.

Pages 4 and 5: Copayment amounts have been reduced

- Copayments on many prescription drugs have been reduced or eliminated. Copayments are \$0 - \$3. Your pharmacy knows the correct copayment and will charge you the reduced amount.

Page 5: OHP Standard benefit added - effective Jan. 1, 2012

- OHP Standard now covers scheduled, medically appropriate, inpatient and outpatient hospital care and surgeries, in addition to emergency hospital services.

Pages 7 and 49: Phone number for OHP Premium Billing Office

- The phone number is 1-888-647-2729.

Page 7: Benefit packages - CAWEM Plus benefit package available in some counties

- Eligibility: The program helps pregnant women receiving CAWEM benefits who live in the following counties:
 - Benton
 - Clackamas
 - Columbia
 - Crook
 - Deschutes
 - Douglas
 - Hood River
 - Jackson
 - Jefferson
 - Lane
 - Morrow
 - Multnomah
 - Union
 - Wasco
- Benefits: CAWEM Plus covers all OHP Plus benefits except for sterilizations, therapeutic abortions, hospice services, and Death with Dignity services.

Page 7: Benefit packages - OHP Plus Supplemental available to pregnant adults

- Eligibility: The program helps pregnant adults age 21 or older who receive OHP benefits. If you become pregnant, let your caseworker know.
 - Benefits: Routine vision testing and eyeglasses; some additional dental services.
-

Page 8: Health care services

See page 2 of your coverage letter (not your Medical Care ID) to find out what type of coverage you have.

Page 10: Quick Reference Benefit Chart - Attached (updated Jan. 2013)**Page 11: Benefit packages - OHP Plus Supplemental available to pregnant adults**

- Eligibility: The program helps pregnant adults age 21 or older who receive OHP benefits. If you become pregnant, let your caseworker know.
 - Benefits: Routine vision testing and eyeglasses; some additional dental services.
-

Pages 11 and 12 - Chemical dependency Substance Use Disorder Treatment (replace with the following):

Chemical dependency is now called chemical dependency Substance Use Disorder.

Outpatient treatment and methadone services medication treatment

OHP covers outpatient treatment and methadone medication treatment such as: Methadone, Suboxone, Buprenorphine, Vivitrol and other medication services that help reduce the use of or abstain from alcohol or other drugs.

Some of the outpatient treatment services are:

- Screening and assessment
- Acupuncture
- Detoxification
- Individual and group counseling
- Medication
- Family/couple counseling
- Physical examination
- Urine Analysis (UAs)

Residential treatment services

OHP covers residential treatment services including treatments provided in a 24-hour care facility, for both adults and youth. There are residential treatment facilities that allow parents to bring their young children to treatment with them. Some of the residential treatment services are:

- Screening and assessment
 - Acupuncture
 - Detoxification
 - Individual and group counseling
 - Medication
 - Family/couple counseling
 - Physical examination
 - Urine Analysis (UAs)
-

Page 12: Oregon Tobacco Quit Line telephone number

- English: 800-QUIT NOW (800-784-8669)
 - Español: 877-2 NO FUME (877-266-3863)
 - TTY: 877-777-6534
-

Page 13: Pregnancy care coverage

- Pregnant OHP clients receive services under OHP Plus, OHP with Limited Drug and OHP Plus Supplemental.
 - In some counties, pregnant CAWEM clients receive services under CAWEM Plus.
-

Pages 15, 16 and 17: Medical Identification Card - *Attached (3 pages)*

- The Medical Care ID is now called the Oregon Health ID. You can still use your DHS Medical Care ID.
 - The state only issues the ID when you are new to OHP, your name changes, or your ID number changes.
 - The coverage letter (not the ID) shows your branch office name, phone number, your worker's code, and the benefit package, copayment and plan information for everyone in your household.
-

Page 18 - Medical Transportation Services

Keeping your health care appointments is important. If you do not have your own transportation, you might:

- Take the bus.
- Ask a friend or relative to drive you.
- Find a volunteer from a community service agency.
- Call the transportation brokerage call center that serves OHP clients free of charge in your county.

In some cases, you may be reimbursed for medical transportation expenses. You need to get approval for reimbursement before you go to your health care appointment.

To get approval for reimbursement for medical transportation expenses:

- Contact your DHS branch office if you live in the following counties:

Baker	Clackamas	Crook	Deschutes
Grant	Harney	Jefferson	Malheur
Marion	Multnomah	Polk	Union
Wallowa	Washington	Yamhill	

- For all other counties, contact the transportation brokerage listed on the attached chart.

Page 18: Lane County medical transportation telephone number

Note: Transportation brokerage services are available at no cost to clients who don't have other transportation resources or options and have OHP Plus, OHP Plus Supplemental, CAWEM Plus, or OHP with Limited Drug benefits.

- RideSource (Lane County), call 541-682-5566 or 1-877-800-9899 (TTY 800-735-2900)

Page 18: Oregon Tobacco Quit Line telephone number

- English: 800-QUIT NOW (800-784-8669)
- Español: 877-2 NO FUME (877-266-3863)
- TTY 877-777-6534

Page 19: Service delivery

To find out if you are in a managed care plan or coordinated care organization, look at your coverage letter (not your Medical ID).

Check the "Date of issue" on page 1, and the Managed Care/TPR enrollments field on pages 2 and 3 of your coverage letter, to make sure nothing has changed.

Your worker's phone number is on page 1 of your coverage letter.

Page 19: Pregnancy care coverage

- Pregnant OHP clients receive services under OHP Plus, OHP with Limited Drug and OHP Plus Supplemental.
- In some counties, pregnant CAWEM clients receive services under CAWEM Plus.

Pages 20, 21 and 23: Phone contact updates

If you have a complaint about the way you were treated at a health care appointment, call DMAP Client Services at 1-800-273-0557 (TTY 711).

24/7 Nurse Advice telephone number

- Page 20: 24/7 Health Care Advice, call 1-800-562-4620
- Page 21: Urgent Care Advice, call 1-800-562-4620
- Page 23: Disease or Case Management Program, call 1-800-562-4620

Page 24: Pharmacy Benefit Management Program

Your assigned pharmacy will show in the Managed Care/TPR enrollments field on pages 2 and 3 of your coverage letter (not on your Medical ID).

Page 25: Longer hours for the OHP home-delivery pharmacy

- Customer service is available Monday through Friday, 7:30 a.m. to 5:30 p.m.
-

Page 28: Managed care

- If you are in managed care, you may be enrolled in one or more of the following:
 - Coordinated care organization (CCOA), for coordinated physical, dental and mental health care
 - Coordinated care organization (CCOB), for coordinated physical and mental health care
 - Fully capitated health plan, physician care organization (PCO) or primary care manager (PCM), for physical health care
 - Dental care organization, for dental care
 - Mental health organization or coordinated care organization (CCOE), for mental health care
 - Coordinated care organization (CCOG), for dental and mental health care
 - Managed care organizations may charge copayments. Pregnant clients or clients under age 19 do not pay copayments.
 - Your managed care plan(s) or primary care manager are listed on your coverage letter (not your Medical Care ID). For each family member, match the Managed Care/TPR enrollments letter on page 2 with the information listed on page 3.
-

Page 33: Labor and delivery

Check page 2 of your coverage letter (not your Medical ID) to make sure your newborn is listed.

Page 34 - Problems with your health care services

Your managed care plan's phone number is listed on page 3 of your coverage letter (not on the Medical ID).

Pages 36 and 37: Hearing rights updated for managed care members

- Health plan members may now ask for a DMAP hearing and/or appeal with the plan at the same time.

Page 38: Advance Directives complaint address

- File Advance Directive non-compliance complaints with the State Survey and Certification office:

Health Care Regulation and Quality Improvement
Office of Community Health and Health Planning
Oregon Health Authority
800 NE Oregon Street, Suite 305
Portland, OR 97232
971-673-0546; fax 971-673-0556

Page 40: Who to call for help

Also call your worker if you have not received your coverage letter, or if the coverage letter is wrong.

Your worker's identification code and telephone number are listed on page 1 of your coverage letter (not on the Medical ID).

Page 42: Division of Child Support address, phone, and fax number

Find the address, phone and fax number of your local Child Support office on the Division's website at www.oregonchildsupport.gov.

- Toll free 1-800-850-0228
 - TTY 1-800-735-2900
-

Page 42: Estates Administration Unit phone number

Their Salem phone number is now 503-378-2884.

Pages 44, 45, 46, 47 and 48: Notice of Privacy Practices revised

- The Notice of Privacy Practices now includes information about the Oregon Health Authority (OHA).
- The Notice of Privacy Practices will tell you how the Department of Human Services (DHS) and OHA may use and disclose health information about you.
- Your health information may be shared between DHS, OHA and your health care providers to determine eligibility, coordinate your care and for treatment, payment and health care operations.
- To get the Notice of Privacy Practices:
 - Find the form online at <https://apps.state.or.us/Forms/Served/me2090.pdf>
 - Pick one up at a DHS office (call 1-800-699-9075 for locations)
 - Call the OHP Central Processing Center at 1-800-699-9075, Monday to Friday, 7 a.m. to 6 p.m.

Your Oregon Health Plan (OHP) benefits



The chart below shows what benefits are available under your OHP coverage. Some CCOs may not provide all of your benefits listed below. Work with your CCO to find out if it covers a service you need.

Benefits covered under: OHP Plus, OHP with Limited Drug and Citizen/Alien-Waived Emergent Medical (CAWEM) Plus

Chemical dependency

Dental

- Basic services including cleaning, fillings and extractions
- Urgent or immediate treatment
- Limited other services*

Hearing aids and hearing aid exams

Home health; private duty nursing

Hospice care – not covered for CAWEM Plus clients

Hospital care

- Emergency treatment
- Inpatient and outpatient care

Immunizations

Labor and delivery

Laboratory and X-rays

Medical care from a physician, nurse practitioner or physician assistant

Medical equipment and supplies

Medical transportation

Mental health

Physical, occupational and speech therapy

Prescription drugs – only includes drugs that are not covered by Medicare Part D for OHP with Limited Drug clients

Vision

- Services for medical care
- Limited services for eye health*

*Additional benefits are available to pregnant adults and children who have OHP Plus.

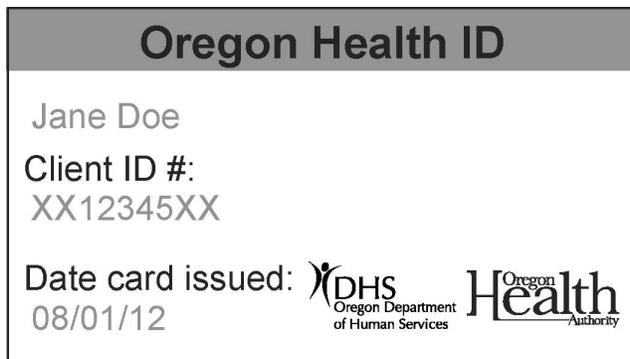
Other benefit packages:

- CAWEM – Covers emergency medical, emergency dental and emergency transport services.
- Qualified Medicare Beneficiary (QMB) – Only covers Medicare premiums and copayments (except for Medicare Part D) and deductibles.

Oregon Health Identification (ID)

The Oregon Health ID is the size of a business card. It lists your name, client ID number and the date it was issued.

Every person who is eligible in your household receives their own Oregon Health ID.



Front



Back

Take your Oregon Health ID to all health care appointments. Providers use the information on the card to check your eligibility.

A new ID card will not be sent unless your name changes, your ID number changes, or you ask for a replacement ID card.

Coverage letter

The coverage letter is for your information only. You do not need to take it to your health care appointments. You will get a new letter when:

- You are new to the Oregon Health Plan;
- You have a new managed care plan, Primary Care Manager or Third Party Resource (TPR - other health care coverage, such as Medicare);
- You get a new ID card; or
- Your benefits, address, or household members have changed.

Sample coverage letter

5503 XX#### XX P2 EN
AT
PO BOX ####
SALEM, OR 97309
DO NOT FORWARD: RETURN IN 3 DAYS

Branch name/Division: OHP/CAF

Worker ID/Telephone: XX/503-555-5555

JOHN DOE
123 MAIN ST

HOMETOWN OR 97000

Keep this letter!

This letter explains your Oregon Health Plan (OHP) benefits.

This letter is just for your information. You do not need to take it to your health care appointments.

We will only send you a new letter if you have a change in your coverage, or if you request one.

Welcome to the Oregon Health Plan (OHP). This is your **new coverage letter**.

This letter lists coverage information for your household. This letter does not guarantee you will stay eligible for services. This letter does not override decision notices your worker sends you.

We will send you a new letter and a Medical ID card any time you request one or if any of the information in this letter or on your Medical ID changes. To request a new letter or Medical ID, call your worker.

The enclosed yellow sheet includes a chart that describes the services covered for each benefit package and a list of helpful phone numbers.

We have listed the reason you are being sent this letter below. The date the information in this letter is effective is listed next to your name.

Reason for letter:

Managed care plan or Primary Care Manager enrollment changed for:

DOE, JOHN – 08/01/2012

DOE, JANE – 08/01/2012

DOE, TIMOTHY – 08/01/2012

How to read the sample coverage letter

Page 1 (sample on previous page)

This page shows your worker's ID and phone number, and why you got the letter.

Page 2 (sample below)

This page lists the benefit package, copayment requirements and managed care or TPR enrollment for everyone in your household who is eligible for benefits.

Name	Date of birth	Client ID#	Co pay?	Benefit Package	Managed Care/TPR enrollments
John Doe	01/01/1968	XXXXXXXX	No	OHP Standard	A, B
Jane Doe	02/01/1968	XXXXXXXX	No	OHP with Limited Drug	B, C, E
Timothy Doe	03/01/2006	XXXXXXXX	No	OHP Plus	D

Page 3 – Managed Care/TPR Enrollment (sample below)

This page lists the names and phone numbers for managed care plans and TPR. TPR is other health coverage, such as private insurance, Medicare, or an assigned pharmacy.

A	CCOB - Mental and Physical COORDINATION INC 800-555-1212	B	Dental Care Organization QUALITY CARE 866-555-1212	C	Mental Health Organization HEALTHY MIND CARE 888-555-1234
D	Private Maj Med/Rx/Den BLUE CROSS OF OREGON Pol # 12345ABC789	E	Medicare Part - A MEDICARE NW - PART A	F	

The sample shows the following coverage information:

John – Does not pay copayments, has OHP Standard benefits and is enrolled in:

- **A** – Coordinated Care Organization: Coordination Inc., for physical and mental health care
- **B** – Dental Care Organization: Quality Care, for dental care

Jane – Does not pay copayments, has OHP with Limited Drug benefits and is enrolled in:

- **B** – Dental Care Organization: Quality Care
- **C** – Mental Health Organization: Healthy Mind Care
- **E** – Medicare Part A: Medicare NW, for hospital care

Timothy – Does not pay copayments, has OHP Plus benefits and is not enrolled in any OHP managed care plans because he has private health insurance:

- **D** – Private Health Insurance: Blue Cross of Oregon, for physical health care, dental health care and prescription coverage

Transportation Brokerages

Use the brokerage in your county to ask for approval and receive reimbursement for your medical transportation costs.

Counties served	Brokerage
Benton Linn Lincoln	Cascades West Ride Line Cascades West Council of Governments Phone: 541-924-8738 Toll-free: 866-724-2975
Baker* Jefferson* Crook* Malheur* Deschutes* Union* Grant* Wallowa*	Cascades East Ride Center Central Oregon Intergovernmental Council Phone: 541-385-8680 Toll-free: 866-385-8680
Lane	RideSource Call Center Lane Transit District Phone: 541-682-5566 Toll-free: 877-800-9899
Gilliam Umatilla Hood River Wasco Morrow Wheeler Sherman	Transportation Network Mid-Columbia Council of Governments Phone: 541-298-5345 Toll-free: 877-875-4657
Coos Josephine Curry Klamath Douglas Lake Jackson	TransLink Rogue Valley Transit District Phone: 541-842-2060 Toll-free: 888-518-8160
Marion* Polk* Yamhill*	TripLink Salem Area Mass Transit District Phone: 503-315-5544 Toll-free: 888-315-5544
Clatsop Columbia Tillamook	Northwest Ride Center Sunset Empire Transit District Phone: 503-861-7433 Toll-free: 866-811-1001
Clackamas* Multnomah* Washington*	Transportation Services Tri-Met Phone: 503-802-8700 Toll-free: 800-889-8726

**Note: The brokerage in these counties will not be providing client reimbursement on July 1, 2013. They may delay until January 1, 2014.*

For TTY/Relay Service, dial 711.

Department of Human Services

Division of Medical Assistance Programs

500 Summer St NE, E35

Salem, OR 97301-1077

If you need this booklet in another language, large print, Braille, on tape, or another format, call 1-800-359-9517 or TTY 1-800-621-5260.

Si necesita este folleto en otro idioma, letra más grande, Braille, cinta de audio, o en otro tipo de formato, llame al 1-800-359-9517 o al 1-800-621-5260 (TTY).

Spanish

Если Вам нужна эта брошюра на другом языке, напечатанная большими буквами, на брайле, на кассете или в каком-нибудь другом формате, пожалуйста, позвоните по телефону 1-800-359-9517 или TTY 1-800-621-5260.

Russian

Nếu quý vị cần tập tài liệu này bằng một ngôn ngữ khác, in khổ chữ lớn, chữ nổi (Braille), băng ghi âm, hoặc hình thức khác, xin gọi điện thoại số 1-800-359-9517 hoặc TTY (dành cho người bị điếc) 1-800-621-5260.

Vietnamese

Dacă doriți această broșură în altă limbă, caractere mari, Braille, înregistrată pe casetă audio, sau în alt format, telefonați la 1-800-359-9517 sau TTY la 1-800-621-5260.

Romanian

បើអ្នកត្រូវការកូនសៀវភៅនេះជាភាសាមួយទៀត ជាអក្សរពុម្ពធំៗ ជាប្រេល ជាវិទ្យុអាត់សម្លេង ឬតាម ទំរង់ផ្សេងទៀត សូមទូរស័ព្ទលេខ 1-800-359-9517 ឬ TTY 1-800-621-5260 ។

Cambodian

ຖ້າທ່ານຕ້ອງການປຶ້ມນ້ອຍເຫຼືອນີ້ ເປັນພາສາອື່ນອີກ, ແບບຕົວໃຫຍ່, ເປັນແບບໜັງສື ສໍາຫຼັບຄົນຕາບອດ, ແບບເທບອັດສຽງ, ຫຼືແບບອື່ນໆອີກ, ໃຫ້ໂທຫາ 1-800-359-9517 ຫຼື TTY 1-800-621-5260.

Lao

Yog haistia koj xav tau phau ntawv no ua lwm yam lus, luam tus ntawv kom loj, ua Ntawv ig muag (Braille), kaw rau hauv kab xev, los yog lwm yam, hu rau 1-800-359-9517 los yog TTY 1-800-621-5260.

Hmong

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

Mien

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

Korean

Accessible services

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

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

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



Is access a problem?

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

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

You have a right to complain if:

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

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

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

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

– or send to –

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

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

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Welcome to the Oregon Health Plan

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



This booklet will help you understand:

- The different ways people receive care under OHP managed care and fee-for-service.
- How to read your Medical Care Identification.
- Health care coverage under OHP.
- The benefit packages under OHP.
- How to use the health services that are covered under OHP.
- What you need to know about managed care under OHP.

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

What is the Oregon Health Plan?

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

Under OHP:

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

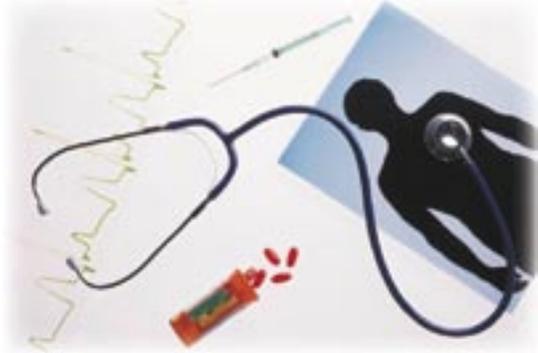
Medicaid is not the same as Medicare

Many people confuse the terms Medicaid and Medicare. Medicaid (OHP) serves qualified clients of any age who have limited income and assets. The Social Security Administration runs the Medicare health insurance program. Some people are eligible for both Medicaid and Medicare. They can receive benefits from both programs at once. Medicare serves people who fit at least one of the following descriptions, regardless of income:

- Age 65 or older
 - Any age with kidney failure or long-term kidney disease
 - People with permanent disabilities who are unable to work
-

Prioritized List of Health Services

Oregon Health Plan clients receive benefits based on where health care conditions and treatments are placed on a Prioritized List of Health Services. The



Oregon Health Services Commission (HSC) developed the List. The HSC is made up of doctors, nurses, and others concerned about health care issues. The Governor appoints them.

To create the first Prioritized List of Health Services, the HSC held many public meetings throughout the state to find out what health issues were important to Oregonians. The

HSC then used that information to rank all health care procedures in order of effectiveness.

The HSC meets regularly to update the list. The Oregon Legislature does not have enough money to pay for everything on the list, so they use the money that is available to pay for the most effective services.

All managed care plans and health care providers use this list to decide if they can provide a service under OHP.

OHP covers reasonable services for finding out what's wrong. That includes diagnosing a condition that is not currently funded. Once they decide on a diagnosis or treatment that's not funded, OHP will not pay for any more services for that condition.

OHP only pays for treatments for a condition not on the currently funded part of the list if it is directly related to another condition whose treatment is funded. Your doctor will know if this applies to you. See page 9 to learn more about services that are not covered by OHP.

Benefit packages

The medical, dental or mental health services OHP covers for each client is called a "benefit package." Each client receives a benefit package based on certain things, such as age or condition. Members of your household may receive different benefit packages. Fields 9a and 9b of your Medical Care ID (see sample on page 17) show which benefit package each household member receives. An explanation of each benefit package appears below. A quick reference chart on page 10 lists the benefits for each benefit package at a glance.

OHP Plus benefit package

Eligibility

You receive the comprehensive OHP Plus benefit package if you are:

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

Coverage

OHP Plus covers medical, dental, mental health and chemical dependency services. OHP Plus covers on all the services listed on page 8-9 plus:

- Hearing services, hearing aids and batteries
- Home health
- Hospital stays
- Physical, occupational and speech therapy
- Private duty nursing
- Routine vision testing and eyeglasses
- Transportation to health care services



Copayments

Some OHP Plus clients are required to make copayments for outpatient services

and prescription drugs. If you are enrolled in a managed care plan, you don't have to pay the plan a copayment for their services.

Amounts of OHP Plus copayments are:

- \$2 for generic and \$3 for brand name prescription drugs (for each filled prescription).
- \$3 for outpatient services (such as office visits to see a doctor, dentist or other health care provider). The copayment is only for the visit to the provider.

You do not have to pay a copayment for:

- Family planning services and supplies, such as birth control pills.
- Prescription drugs ordered through the OHP Home-Delivery Pharmacy Program. See page 25 for more information about this program.
- Emergency services.
- Lab tests, shots, durable medical equipment or x-rays.
- Services received from your OHP managed care organization.

If you cannot pay

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

OHP with Limited Drug benefit package

OHP Plus with Limited Drug is a comprehensive package of services that focuses on preventive care (pages 8-10). Only the prescription drug coverage is limited.

Eligibility

You receive this benefit package if you are eligible for both Medicaid and Medicare Part D.

Coverage

The OHP with Limited Drug package covers all the same medical, dental and mental health benefits as the OHP Plus package. However, this package does not cover prescription drugs that Medicare Part D pays for. OHP does pay for some other drugs that Medicare does not cover.

Note: OHP will not pay for types of drugs that Medicare Part D would cover, even if you choose not to enroll in a Medicare drug plan. You will have to pay for them yourself.

Copayments

You may have to make a copayment for the outpatient services and prescription drugs you receive outside your managed care plan. Copayments are:

- \$3 for outpatient services, such as office visits to see a doctor or other health care provider. You do not have to make copayments for treatments such as shots, lab tests or x-rays. You do not have to pay for emergency services.
- \$2 for generic and \$3 for brand name prescription drugs, for each filled OHP prescription.

Different, mandatory copayments of \$1 to \$5 apply to your Medicare Part D drugs. OHP does not pay Medicare premiums, deductibles or copayments for Medicare Part D drug plans or services.

OHP Standard benefit package

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

Eligibility

You receive OHP Standard benefits if you do not meet the requirements for OHP Plus or other benefit packages, but your income fits in the OHP Standard range. The department accepts new, qualified applicants into the OHP Standard package only when the program is open for enrollment. Presently OHP Standard is closed to new enrollees.

Your benefit package may change

Current OHP clients may transfer from another OHP benefit package into OHP Standard if they qualify. If you become pregnant, disabled, turn 65, or meet other qualifications, call your worker. You may be eligible for the OHP Plus or OHP with Limited Drug benefit packages.

Coverage

See pages 8-10 for the list of health services almost everyone may receive. OHP Standard is a reduced benefit package whose coverage is limited as follows:

- Acupuncture is covered only for chemical dependency treatment.
- Chemical dependency and mental health services are covered.
- Hospital care is limited to urgent or emergency services.
- Medical equipment and supplies coverage is limited to diabetic supplies, respiratory equipment, oxygen equipment, ventilators, suction pumps, tracheostomy supplies, urology and ostomy supplies.

- The only medical transportation covered is emergency ambulance (and only if the Division of Medical Assistance Programs [DMAP] considers it an emergency).
- Vision care covers only eye diseases or injury (no glasses or tests for glasses).

Copayments

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

Premiums

Many clients who receive OHP Standard benefits must make a monthly payment for health care coverage. This monthly payment is called a premium. Premium amounts are based on a family's income and size at the time of enrollment. The amount will not increase during your enrollment period.

You don't have to pay premiums if:

- Your household income is ten percent or less of the Federal Poverty Level when you apply or reapply.
- You are American Indian or an Alaska Native.
- If you are eligible for services through an Indian Health Services program.

Your premium requirement will begin the date your coverage begins. If you are required to pay a premium, you will receive a bill in the mail each month. You owe monthly premiums even if you didn't see your health care provider.

Premiums must be paid in full

You will not lose coverage during your current enrollment period just because you have a past-due premium. However, when your enrollment period is ending and you reapply, you will need to pay all billed premiums before you can qualify for another six months of coverage.

You will receive a notice when it is time to reapply. When you reapply, your worker will tell you if you have past-due premiums and give you a deadline by which to pay them. **If you do not pay your past-due premiums by the deadline, you will not be able to enroll in OHP Standard again until:**

- The program is open to new clients, and
- You have paid all your billed premiums.

Any clients in the household (children, for example) who are not required to pay premiums may reapply as usual. If they are still eligible, these clients will continue to receive benefits even if others in the household do not renew their coverage.

How to pay your premiums

Send your check or money orders to the post office box below. A pre-addressed envelope comes with your bill. The billing office staff will accept cash only if presented in person at the Baker City address. Your local DHS office cannot accept premium payments in any form. A new company will run the OHP Premium Billing Office effective April 1, 2007.

Contact the OHP premium billing office to:

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

OHP Premium Billing Office

Mailing address:

Pay in person at:

Local phone: 541-523-3602

Fax: 1-800-261-3317

Web site: <OHPbilling.com>

Phone: 1-800-261-3317

PO Box 1120, Baker City, OR 97814-1120

1705 Main Street, Suite 300, Baker City

Toll-free TTY: 1-800-264-6958

E-mail: Support@OHPbilling.com

Qualified Medicare Beneficiary (QMB) benefit package

Eligibility

This program helps you if you are eligible to receive hospital benefits through Medicare. QMB clients have limited income but are not eligible for Medicaid.



Coverage

The state helps by paying for QMB clients' Medicare premiums, deductibles and coinsurance. However, OHP does not pay for premiums or copayments for Medicare Part D drug plans or services. If you have QMB-only, Medicare pays your health care costs, not OHP.

Clients may be eligible for more than one benefit package at once. For example, a person with QMB benefits may also be eligible for OHP with Limited Drug benefits.

Citizen Alien-Waived Emergency Medical Assistance (CAWEM) benefits

These clients are not citizens of the United States and do not have an immigration status that meets Medicaid requirements. Coverage is limited to emergency services and labor and delivery services.

Health care services

The health service you may receive are based on your assigned benefit package. See Fields 9a and 9b on your Medical Care ID to find out what type of coverage you have. Benefit packages are defined on pages 3 through 7.

See the quick reference chart on page 10 that shows what services are covered for each benefit package.

Preventive services

Preventing health problems before they happen is an important part of your care.

Under OHP, you can get preventive services to help you stay healthy. Preventive services include check-ups and any tests to find out what is wrong. Be sure to discuss the recommended schedule for check-ups with your provider. Other preventive services include the following:

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



Some services have limits. Your provider can help answer your questions about limited services. There are some services that are not covered even if treatment may be important. If you get a health care service that is not covered, you may have to pay the bill. Your provider will tell you if a service is not covered and what choices you have.

Medical services

Services covered by OHP Plus, OHP with Limited Drug and OHP Standard all include the following:

- Preventive services
- An exam or test (laboratory or x-ray) to find out what is wrong, whether the treatment for the condition is covered or not
- Treatment for most major diseases
- 24-hour emergency care, x-ray, and lab services
- Chemical dependency (alcohol and drug) treatment
- Eye health care
- Hospice
- Labor, delivery and newborn care
- Some surgeries
- Most prescription drugs
- Family planning
- Specialist care and referrals
- Stop-smoking programs
- Diabetic supplies and education
- Medical equipment and supplies
- Emergency ambulance

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

Not covered services

OHP covers reasonable services for diagnosing conditions, including the office visit to find out what's wrong. However, once they know what's wrong, OHP may not cover follow-up visits if the condition or treatment is not funded on the Prioritized List of Health Services (see page 2).

For example, OHP does *not* pay for the following services:

- Treatment for conditions that get better on their own (such as colds or flu)
- Treatment for conditions for which home treatment works (such as sprains, allergies, corns, calluses or some skin conditions)
- Cosmetic surgeries or treatments
- Treatments that are not generally effective
- Services to help you get pregnant
- Weight loss programs
- Buy-ups – To "buy up" means you get an item that is not covered by OHP by paying the difference between the item OHP covers and a more expensive, non-covered model. For example, OHP may cover a basic pair of eyeglasses but the client may want a more expensive pair that is not covered by OHP. The client tries to "buy up" by paying the difference between the two. This is not allowed.

Quick reference benefits chart

Covered Services	OHP Standard	OHP Plus	OHP with Limited Drug
Acupuncture	Limited	✓	✓
Chemical dependency services	✓	✓	✓
Dental	Limited	✓	✓
Emergency medical services	✓	✓	✓
Hearing aids and hearing aid exams		✓	✓
Home health		✓	✓
Hospice care	✓	✓	✓
Hospital care	Limited	✓	✓
Immunizations	✓	✓	✓
Labor and delivery	✓	✓	✓
Laboratory and X-ray	✓	✓	✓
Medical equipment and supplies	Limited	✓	✓
Medical transportation	Limited	✓	✓
Mental health services	✓	✓	✓
Physical, occupational & speech therapies		✓	✓
Physician services	✓	✓	✓
Prescription drugs	✓	✓	Limited*
Private duty nursing		✓	✓
Vision care	Limited	✓	✓
* OHP with Limited Drug does not pay for certain prescription drugs that Medicare Part D covers. OHP does pay for some other drugs that Medicare does not cover.			
QMB covers Medicare premiums, copayments (except on drugs), and deductibles.			
CAWEM clients receive only emergency or labor and delivery services.			

OHP offers more services and places more limitations than we can list here. This chart is meant to be a guide, not OHP policy.

If you have questions about what OHP will pay for, ask your managed care plan or the DMAP Client Advisory Services Unit (see CASU, page 41).

Dental services include the following:

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



NOTE: OHP Standard dental coverage is limited to emergency services only.

Mental health services include the following:

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

Chemical dependency treatment

The chemical dependency services you may receive are based on the benefit package you have been assigned to. Problems with alcohol or other drugs affect the whole family. You may need treatment if drinking alcohol or using other drugs causes problems such as these in your life:

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

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

- Any provider who will take your Medical Care ID.
- Your primary care provider or primary care manager.

Outpatient treatment and methadone services

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

Residential services

Residential services include treatments provided in a 24-hour care facility. OHP does not cover residential services; however, if needed, you may get residential services from other programs.

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

- 1-800-923-HELP (4357) or 1-877-553-TEEN (8336)—youth line
- 1-877-515-7848 for Spanish-speaking clients
- 503-945-5962—The DHS Addictions and Mental Health Medicaid Policy Unit can also answer your questions about these type services.

Stop smoking programs

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

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



Pregnancy care coverage

Pregnancy care is covered under the OHP. If you become pregnant, call your worker right away. Your worker will make sure you do not lose medical coverage before your baby is born. You also need to tell your worker if a pregnancy ends.

Pregnant clients:

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

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



Remember!

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

Newborn care coverage

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

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

- Date of birth
- Name
- Sex
- Social Security number (or call again as soon as your baby gets one)
- Your primary care provider or primary care manager



Family planning and related services

The following family planning and related services are available to women, men and teens:

- Family planning visits (physical exam and contraceptive education)
- Contraceptive supplies, such as oral contraceptives and condoms
- Sterilization services (tubal ligations and vasectomies)

"Related services" include the following:

- Pap smear
- Pregnancy test
- Screenings for sexually transmitted diseases (STDs)
- Abortions
- Testing and counseling for AIDS and HIV

Even if you're in managed care, you can go to any one of the following places to receive family planning services.

- A county health department
- A family planning clinic
- Any provider who will take your Medical Care ID

There is no copayment for any of the family planning and related services or supplies.

Medical Care Identification (ID)

The state sends a Medical Care ID to OHP clients each month. Check your Medical Care ID to make sure the information is correct. If it is not, call your worker. Always carry your current Medical Care ID. Show it every time you get health care services.

Your Medical Care ID shows your branch office name, phone number, your worker's code, and the benefit package and copayment information for everyone on the ID. See the sample ID and explanations on pages 16 and 17.

Changes to your Medical Care ID

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

It is illegal to use your Medical Care ID for health services for anyone not listed on your ID.

How to read your Medical Care ID

The sample on the next page gives us the following information about John Doe, who has a permanent disability.

- John finds "AB" written in Field 7b, "copayments." Field 7a at the top of the page tells him how much he will pay for outpatient services and OHP prescription drugs.
- John's ID shows an "FG" in Field 8b. Boxes "F" and "G" in Field at the top of the page show that John is enrolled in Medicare Parts A, B and D.
- Field 9b, Benefit Package, shows a "CD." Field 9a explains that "C" means QMB and "D" is OHP with Limited Drug.

The sample ID gives us the following information about Janie Doe, who was born in 1984:

- Field 7b for Janie spells out "NO COPAYS," so Janie knows she will not have to make copayments.
- Field 8b has the letters "ABC" in it. Field 8a shows that Janie is enrolled in a DMAP medical plan ("A"), a DMAP dental plan ("B") and a DMAP mental health plan ("C").
- The "B" in Field 9b shows that Janie receives OHP Plus benefits.

Young Jacob's information on the sample ID shows the following:

- He has "NO COPAYS" 7b and has the OHP Plus benefit package 9b.
- He is enrolled in DMAP medical (A) and dental (B) plans. He also has private vision, mental health and medical insurance coverage "C, D,E" in 8a.
- His Medicaid ID and date of birth are listed in Fields 11 and 12.
- Field 13 shows Jacob is covered for the month of January.

Medical transportation

You must find a way to get to your health care appointments. If you transport yourself, ask your worker if OHP can reimburse you for your expenses . If transportation is a problem, you might:

- Take the bus.
- Ask a friend or relative to drive you.
- Find a volunteer from a community service agency.
- Call the transportation call center that serves OHP clients free of charge in your county.

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

Brokerages include:

Cascades East Ride Center (Baker, Crook, Deschutes, Grant, Harney, Jefferson, Malheur, Union and Wallowa Counties)	541-385-8680	TTY: 800-735-2900
Cascades West Ride Line (Benton, Linn, Lincoln Counties)	541-924-8738	TTY: 541-928-1775
Lane Transit (Lane County)	Pending	
Northwest Ride Center (Columbia, Clatsop, Tillamook Counties)	503-861-7433	TTY: 7-1-1
TransLink (Coos, Curry, Douglas, Jackson, Josephine, Klamath, Lake Counties)	541-842-2060	TTY: 7-1-1
Transportation Network (Hood River, Gilliam, Morrow, Sherman, Wasco, Wheeler, Umatilla Counties)	541-298-5345	TTY: 7-1-1
Transportation Services (Tri-Met) (Clackamas, Multnomah, Washington Counties)	503-802-8700	TTY: 7-1-1
Trip Link (Marion, Polk, Yamhill Counties)	503-315-5544	TTY: 7-1-1

Service delivery

There are two ways to receive health care through the Oregon Health Plan. They are fee-for-service (FFS) and managed care. Be sure to look your Medical Care ID for "Dates of Coverage" (Field 13) and "Managed Care/TPR" (Field 8) to see if you are enrolled in a managed care plan.

Depending on where you live and other factors, you may be enrolled in a managed care plan for some kinds of health care and receive health care from any provider who will take your Medical Care ID for other services. For instance, you may be in a medical plan and a mental health plan, but not a dental plan. For information about managed care services, please turn to page 28.

Some clients receive health care from FFS providers for the first part of a month and then are enrolled in a managed care plan for the remainder of the month. Check the "Dates of Coverage" and "Managed Care/TPR" fields of your ID every month to make sure nothing has changed. If you have questions about the information on your ID, call your worker. Your worker's phone number is located in Field 6 on your Medical Care ID.



Reasons why clients may not be enrolled in a plan include:

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

Fee-for-service

Fee-for-service (FFS) means that you are not enrolled in a managed care plan. If you are not enrolled in managed care, you can receive health care from any provider who will take your Medical Care ID. You may need to call doctors' offices to find out if they accept OHP clients. That provider will bill DMAP directly for any services provided and will receive a "fee" for his or her "service." Some people call this an "open card."

If you are a fee-for-service client, the "Managed Care/TPR" Field 8 on your Medical Care ID will not show an OHP managed care plan. However, if you have private insurance, that insurance will be listed in this column. (TPR stands for Third Party Resource.)

Problems with health care services

If you have a complaint about the way you were treated at a health care appointment (such as staff rudeness or unresolved billing):

- Call the DMAP Client Advisory Services Unit (CASU) at 1-800-273-0557 (TTY 1-800-375-2863).
- Fill out an OHP complaint form (OHP 3001). You can get this form from CASU, from your worker or on the DHS Web site: <http://dhsforms.hr.state.or.us/Forms/Served/HE3001.pdf>.
- If you disagree with a decision about your health care made by DMAP, complete an Administrative Hearing Request form (DHS 443). Your worker can give you the form. See page 36 for more information about your rights to a hearing.

24-hour health care advice

Sometimes when you or your child gets sick or hurt, you can't tell if you need to see a doctor or not. Other times, you know you need medical care, but you don't know if you should wait to see your regular provider or go to an urgent care center or hospital emergency room.

If you receive care on a fee-for-service basis, you may call the nurse advice line at 1-800-711-6687. The nurse will ask some questions, then help you decide where to get treatment. Maybe you do not need a trip to the hospital. The nurse may even call back later to see how you are.

The nurses are available 24 hours a day, seven days a week. This service is free.

Emergency medical care

An emergency is a serious injury or sudden illness, including severe pain, that you believe might cause death or serious bodily harm if



left untreated. If you are pregnant, emergency services also include your unborn baby's health. If you believe you have an emergency, call 9-1-1 or go to the nearest emergency room. Emergency care is covered 24 hours a day, 7 days a week.

Take your ID

At the emergency room, show your Medical Care ID. The emergency room staff will call your provider if they need to know more about you.

Emergency care when you're away from home

If you are traveling and have an emergency, go to the nearest emergency room or call 9-1-1. Emergency services are only authorized for as long as the emergency exists. Call your primary care provider to arrange for further care if it is needed while you are gone. Also, call for follow-up or transfer of your care.

If it's not really an emergency

If you use an ambulance or the emergency room for something that DMAP does not consider an emergency, you may have to pay the bill. Emergency room care is very expensive. Do not go to the emergency room for care that should take place in your provider's office. Care for sore throats, colds, flu, back pain or tension headaches is not considered an emergency. Call your provider or the 24-hour nurse advice line instead.

Urgent care

An urgent medical condition is serious enough to be treated right away, but does not require emergency room care. For urgent care, call your provider. They will give you advice on what to do. If you cannot reach your provider, call the 24-hour nurse advice line, 1-800-711-6687, or go to an urgent care center. If you have a mental health crisis, call your mental health plan.

Follow-up to emergency or urgent care

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

Dental emergency and urgent care

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

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

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

- A toothache
- Swollen gums
- A lost filling

If you have a dental emergency or urgent care need, call your regular dentist.



Disease or Case Management Program

You may be placed in a special program if you have certain chronic conditions, such as:

- Diabetes
- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)

You may also be placed in the case management program if you have certain multiple medical needs. The goal of the program is to keep you healthier longer.

If you are part of the program, you receive extra help, advice or visits from nurses about how to care for yourself. You will also learn how to work with your providers to coordinate your care among all of your health care professionals.

You may call the 24-hour nurse advice line at 1-800-711-6687 any time you have questions about your condition. The program also provides a library of resources to learn more about your health condition.

Care away from home

If you travel outside of Oregon, OHP only covers emergency services. You may be billed for out-of-state emergent care if the provider does not enroll as a DMAP provider.

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

Travel outside of the United States

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



Pharmacy Management Program

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

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

- Are enrolled in a medical plan.
- Have Medicare drug coverage in addition to OHP FFS and no other third party pharmacy insurance coverage;
- Are an American Indian, Alaska Native or eligible for benefits through an Indian Health Services program.
- Are a child in the care and custody of the Department of Human Services.
- Are an inpatient or resident in a hospital, nursing facility, or other medical institution, or receiving services under the Home and Community Based or Developmental Disability waivers.

How the program works

When your first prescription is filled, you will be enrolled with the pharmacy that fills the prescription. DMAP will send you a new Medical Care ID showing the enrolled pharmacy in Field 8, Managed Care/TPR, on the ID.



You will have 30 days to change pharmacies if you do not want to be enrolled in the pharmacy listed on the Medical ID. To change pharmacies, call the DMAP Client Advisory Services Unit (CASU) at 1-800-273-0557 or TTY at 1-800-375-2863.

Exceptions allowed

You may receive drugs from a different pharmacy if:

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

You may change your pharmacy enrollment:

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

OHP home-delivery pharmacy services

This program lets fee-for-service clients order and receive medications in the mail at home or at your clinic. You do not have to make copayments for drugs provided through the DMAP Home-Delivery Pharmacy. You can:

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



You can use these services even if you are restricted to one walk-in pharmacy through the Pharmacy Management Program. Your doctor can send your prescription to the home-delivery service or you can enroll yourself by calling 1-877-935-5797 toll-free. Customer service representatives are available Monday through Friday from 8 a.m. to 5 p.m.

When you need help

If you get a bill

Copayments are your responsibility. Providers may bill you for unpaid copayments. If you get a bill (other than for a copayment) from a provider, call OHP Client Advisory Services Unit at 1-800-273-0557 (TTY 1-800-375-2863) if you are fee-for-service or you have a PCM.

NOTE: If you pay a medical, dental, or mental health bill yourself, DMAP will not pay you back.

Client access to clinical records

An OHP client may have access to his or her own clinical records. A client may also ask to have his or her medical records corrected. More client rights and responsibilities follow on the next two pages.

More helpful numbers

Starting on page 40, read when to call your worker or how CASU can help you with other questions you may have. We have listed more services available to you and your family in the back of this booklet.

OHP client rights

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

OHP client responsibilities

- To treat all providers and personnel with respect
- To be on time for appointments made with providers
- To call in advance if you are going to be late or have to cancel your appointment
- To seek periodic health exams, check-ups, and preventive services from your medical, dental or mental health providers
- To use your PCP or clinic for diagnostic and other care, except in an emergency
- To obtain a referral to a specialist from the PCP or clinic before seeking care from a specialist, unless self-referral is allowed
- To use emergency and urgent care services appropriately
- To give accurate information for inclusion in the clinical record
- To help the provider or clinic obtain clinical records from other providers. This may include signing a release of information form
- To ask questions about conditions, treatments and other issues related to your care that you don't understand
- To use information to make informed decisions about treatment before it is given
- To help in the creation of a treatment plan with your provider
- To follow prescribed, agreed-upon treatment plans
- To tell your provider you have OHP coverage and to show your Medical Care ID when asked.
- To tell your DHS worker of a change of address or phone number
- To tell your DHS worker if someone in the family becomes pregnant
- To tell your DHS worker of the birth of a child
- To tell your DHS worker if any family members move in or out of the household
- To tell your DHS worker if there is any other insurance available and to report any changes in insurance in timely manner
- To pay for non-covered services you receive
- To pay the monthly OHP premium on time, if required
- To assist DMAP to find any other insurance to which you are entitled and to pay DMAP the amount of benefits you received as a result of an accident or injury
- To notify DMAP of issues, complaints or grievances
- To sign a release so that DHS and your plan can get information that is pertinent and needed to respond to an Administrative Hearing request in an effective and efficient manner

Managed care

In managed care, a managed care plan or primary care manager (PCM) coordinates your health care needs.

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

- Medical plan or PCM (for physical health care)
- Dental plan
- Mental health plan
- Chemical dependency plan (available in Deschutes County only)

What are the benefits of managed care?

- You will not have to pay copayments.
- You and your family will have guaranteed access to health care 24 hours a day, 7 days a week.

Interpreter services

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

Identification cards

Your medical and dental plans will send you identification cards. They tell you what to do in an emergency. It is important to show both your DMAP Medical Care ID and your plan ID when you seek health care. Call the plan's member services department to replace lost plan ID cards.

Managed care plan or primary care manager

The managed care plans or primary care manager (PCM) you are enrolled with are listed on your Medical Care ID. For each family member, match Field 8b with Field 8a.

Primary care provider in a medical plan

When you enroll in a medical plan, your medical plan will ask you to choose a primary care provider (PCP). Each family member may choose a different PCP. Your PCP will provide or coordinate your medical services and treatments. Your medical plan will give you 30 days to choose a PCP. After 30 days, your medical plan may choose

a PCP for you. Ask your plan for a list of providers if you don't have one.

Primary care manager (PCM)



Medical plans are not available in all areas of the state, or to all clients. In order to make sure OHP clients can still receive the advantages of managed care, DMAP also contracts with individual providers to coordinate and manage your health care. These providers are called primary care managers (PCMs). Each family member may choose a different PCM. If you are enrolled with a PCM, your PCM will provide and coordinate your medical services and treatments.

To coordinate your medical care, your PCP or PCM will:

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

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

You may change your managed care plan or PCM

- When you reapply for OHP coverage.
- If you move out of your plan's service area, or away from the PCM.
- For any important reason that DMAP approves.
- To change your plan or PCM, call your DHS worker.

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

Special services

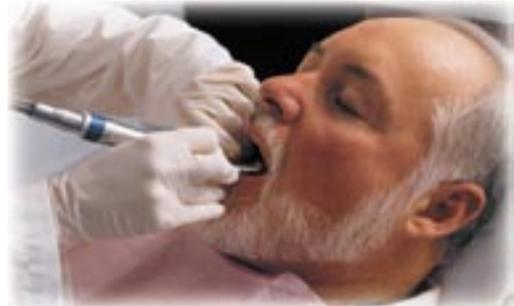
- You must have a referral from your plan or PCM before you see a specialist. If you do not have a referral, OHP may not pay for the care you receive. You may have to pay the specialist's bill.
- However, you do not need a referral from your PCP or PCM to get family planning and related services. You may seek this type of help from anyone who will take your Medical Care ID.
- You will get your prescription drugs at the pharmacies your managed health plan contracts with. Ask your plan for a list.

Exceptional Needs Care Coordinator (ENCC)

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

Dental plans

If you are enrolled in a dental plan, your dental plan will ask you to choose a dentist from their list of providers. Each family member may choose a different dentist. Your dentist will provide and coordinate your dental services and treatments.



To coordinate your dental care, your dentist will:

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

Mental health plans

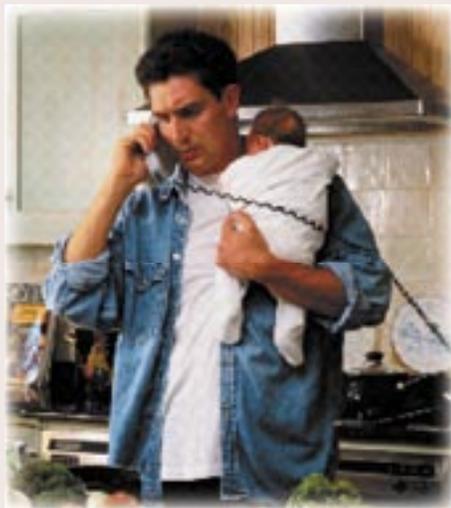
If you are enrolled in a mental health plan, your mental health plan will provide and coordinate your mental health services and treatments.

Mental health services include an assessment, case management, therapy, medication management and inpatient psychiatric care from the appropriate mental health plan.

You must get your mental health drugs at the pharmacy your medical plan contracts with.

To coordinate your mental health care, your mental health plan will:

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



24-hour health care advice

Your plan's client handbook tells you what to do if you need emergency or urgent care services. Sometimes when you or your child gets sick or hurt, you can't tell if it is an emergency or not. Call your managed care plan and ask where to get treatment. Someone is available to give you advice 24 hours a day, seven days a week. Speak to the provider on call, even if he or she is not your usual provider.

If you go to the emergency room

If you go to an emergency room or urgent care clinic, show both your Medical Care ID **and your medical plan card**. The emergency room staff will call your provider if they need to know more about you.

Follow-up to emergency or urgent care

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

Care away from home

If you need health care services while you are traveling, call your PCP or PCM for advice. Your plan may not pay for services it does not authorize first. If you travel outside the United States (including Canada and Mexico), OHP will not cover any health care services you get in another country. If you have Medicare coverage and you are in managed care, contact your medical plan to find out about your coverage while traveling.

Labor and delivery

If at all possible, try to stay within your medical plan's service area during the last 30 days of your pregnancy.

However, if you must leave your medical plan's service area, your plan is only responsible for emergency care outside the plan's service area. The plan will cover the delivery and the baby's newborn check-up in the hospital but not the prenatal care. The plan will also pay for any other emergency care involving you or your baby.

Newborn enrollment

Your managed care medical plan will cover your newborn child at the time of birth. However, you will still need to call your DHS worker to enroll your baby in your plan as soon as possible (within two weeks is best). Check your next Medical Care ID to make sure your baby is listed. If not, call your worker.



Managed care member rights

In addition to the rights shown on page 26, as a member of a managed care plan, you also have the right to:

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

Client access to clinical records

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

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

Problems with your health care services

If you have a complaint about the way you were treated at a health care appointment (such as staff rudeness or unresolved billing), choose one of the following:

- Call your managed care plan at the number shown on your Medical Care Identification.
- Call the Client Advisory Services Unit at 1-800-273-0557 (TTY 1-800-375-2863) to discuss your problem.
- Fill out an OHP complaint form (OHP 3001). You can get this form from the DMAP Client Advisory Services Unit, from your worker or on the DHS Web site: <<http://dhsforms.hr.state.or.us/Forms/Served/HE3001.pdf>>. Your plans also have complaint forms.
- See also your Hearing Rights on page 36.

Managed care member responsibilities

In addition to the responsibilities listed on page 27, as a member of a prepaid health plan, you also have the responsibility to:

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

When to call your managed care plan

If you are in managed care, call your plan:

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

If you get a bill

If you get a bill from a provider, call the medical, dental, or mental health plan responsible for your care.

NOTE: If you pay a health care bill yourself, the plan will not pay you back.

If your health plan does not resolve the billing problem, call the OHP Client Advisory Services Unit for help at 1-800-273-0557.

Hearing rights

If you do not agree with a decision made on your request for OHP/Medicaid services, you have the right to ask for a hearing.

You may ask for a hearing through any local DHS branch office. If you do not have a caseworker/case manager, contact OHP at 1-800-699-9075 or TTY (503) 373-0354.

At the hearing, you can explain why you do not agree with the decision made in your case. You can have a lawyer or someone else assist you with the hearing. We cannot pay for the cost of a lawyer; however, you may be able to get a lawyer for free by contacting Legal Aid. The hearing will be held before an impartial person called an Administrative Law Judge (ORS Chapter 183).

Managed care

If you are enrolled in a managed health care plan or dental plan, you may only ask for a hearing after you have appealed the decision with your plan.

If you are not satisfied with the outcome of that appeal, you may then ask for a DMAP hearing by completing an Administrative Hearing Request form (DHS 443) and returning it to DMAP or any local DHS branch office **WITHIN 45 DAYS** from the date of Notice of Appeal Resolution. Please include a copy of the Notice of Appeal Resolution when submitting your request for hearing.

Medicare

If you are enrolled in managed care and also have Medicare benefits, you may have more appeal rights. Contact your plan's member services unit.

Fee-for-service

If you are an open card (fee-for-service) client, you may ask for a DMAP hearing by completing an Administrative Hearing Request form (DHS 443) and returning it to DMAP or any local DHS branch office **WITHIN 45 DAYS** from the date of the decision notice.

If you want your benefits to remain the same while waiting for the outcome of the hearing, you must submit the completed DHS 443 form by the date of action or **WITHIN 10 DAYS** of the date of the decision notice. If the hearing decision is in favor of the agency, you may then have to repay the cost of continued health services. Please include a copy of the decision notice when submitting your request for hearing.

Expedited hearings

If you have an urgent medical problem that cannot wait for a regular hearing, you can ask for an “Expedited Fair Hearing.” The DMAP Medical Director will review your medical records and decide if your medical problem cannot wait for the regular hearing process.

DMAP hearing request mailing address

Send completed hearing request forms (DHS 443) to:

Division of Medical Assistance Programs

Attention: Hearings Unit

500 Summer Street NE, E49

Salem, OR 97301-1079

Your right to make health care decisions

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

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

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

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

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



Health care professionals

The following is a list of identified health care professionals licensed in the State of Oregon.

Not all managed care plans cover the services of all healing arts professionals.

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



Acupuncturists

Audiologists

Chiropractic Physicians

Clinical Social Workers

Counselors, Professional

Dental Hygienists

Dental Specialists

Dentists, General

Denturists

Dieticians

Hearing Aid Dealers

Marriage and Family
Therapists

Massage Technicians

Midwives, Licensed Direct
Entry
(LDEM)

Naturopathic Physicians

Nurses, Licensed Practical

Nurse Practitioners

Nurses, Registered

** Not all psychiatric social workers
are licensed.*

Occupational Therapists

Occupational Therapy
Assistants

Optometrists

Osteopathic Physicians

Physical Therapist Assistants

Physicians, MD

Physician Assistants

Podiatrists

Pharmacists

Physical Therapists

Psychiatric Social Workers*

Psychologists

Psychologist Associates

Radiologic Technologists (Full
License)

Radiologic Technologists
(Limited Permit)

Respiratory Therapists

School Counselors

School Psychologists

Speech Pathologists

Who to call for help

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

The following pages show different offices that may be able to answer your questions. Please read carefully how each office can help you.

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



Call your worker if you:

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

Your worker may tell you to report other changes as well. Your DHS worker's identification code and telephone number are on your Medical Care ID in Fields 5 and 6.

The OHP Statewide Processing Center is 1-800-699-9075 or TTY 503-373-7800. They can answer questions until you have an assigned worker.

OHP Client Advisory Services Unit (CASU)

500 Summer St NE, E44
Salem, Oregon 97301

1-800-273-0557
TTY 1-800-375-2863
FAX 503-945-6898

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

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

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

Certificate of creditable coverage (after you leave OHP)

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

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

The new insurance company may require a certificate of creditable coverage as proof of previous insurance.

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

Division of Child Support

The Division of Child Support (DCS) will set up and enforce child support orders or medical support orders for families who receive public assistance. These support payments:

- Help children in need.
- Encourage family self-sufficiency.
- Return money to the state treasury.
- Reduce the state's costs in providing public assistance.

Assignment of rights

When you applied for OHP services, you gave the state permission to establish paternity and pursue health care coverage from parent(s) not living in your household. DHS is now paying for your child's health care, so the department will keep any money it collects for health care from the absent parent(s) or other insurance companies.

Oregon Department of Justice
Division of Child Support
1495 Edgewater Street NW, Suite 170
Salem, Oregon 97304

Phone: 503-986-6090
Fax: 503-986-6297

Estates Administration Unit

When a Medicaid client dies, Oregon law requires DHS to recover money spent on their care from the "estate" of the client. Money recovered is usually for assistance provided after the client turned 55. However, if the client received General Assistance or was institutionalized at the time of his or her death, assistance that was paid prior to age 55 may be recovered. The money recovered is put back into DHS programs to help other people.

DHS will not make a claim against an estate until the surviving spouse dies. The department will not recover from the estate if the client is survived by a minor child, or a child who is blind or permanently and totally disabled. The child must be a natural or legally adopted.

DHS Estates Administration Unit
P O Box 14021
Salem, OR 97301

1-800-826-5675 (toll-free inside Oregon)
503-947-9975 (Salem)

Personal injury or accident liens

If you, as a Medicaid client, have an accident or injury, you need to tell DHS. Someone else might be responsible to pay for the medical bills that result. When you applied for OHP, you agreed to let DHS have any medical payments you receive, or have the right to receive, from private health insurance or other sources to repay DHS for assistance paid due to the accident or injury. This applies from the date of your injury to the date of a settlement.

If you do not notify DHS of your accident, the department, or your managed care plan, can take legal action (pursue a lien) against you to collect the cost of medical services you received as a result.

DHS Personal Injury Liens Unit

P O Box 14512
Salem, OR 97309

Toll Free 1-800-377-3841

503-378-4514 (Salem)

Domestic violence

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

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



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

Portland Women's Crisis Hotline

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

National Domestic Violence

1-800-799-SAFE (7233)
1-800-787-3224 (TTY)
(Serves both men and women)

DHS NOTICE OF PRIVACY PRACTICES

Effective Date: June 1, 2005

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

This publication will be furnished in a format for individuals with disabilities upon request by telephoning (503) 945-5780, Fax (503) 947-5396 or TTY (503) 945-5928.

Available formats include:

- Large Print
- Braille
- Audio Tape Recording
- Electronic Format, and
- Oral Presentation.

The Department of Human Services (DHS) Notice of Privacy Practices will tell you how DHS may use or disclose health information about you. This information is called Protected Health Information (PHI). Not all situations will be described. DHS is required to protect health information by federal and state law. DHS is required to follow the terms of the notice currently in effect.

DHS may use and disclose information without your authorization

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

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

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

DHS may use or disclose health information without your authorization for the following purposes under limited circumstances:

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

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

For Health Oversight. DHS may use or disclose PHI for government health care oversight activities. Examples are audits, investigations, inspections, and licenses.

For Law Enforcement and As Required by Law. DHS will use and disclose PHI for law enforcement and other purposes as required or allowed by federal or state law.

For Disputes and Lawsuits. DHS will disclose PHI in response to a court order. DHS will disclose PHI in response to an administrative order. If you are involved in a lawsuit or dispute, DHS may share your information in response to legal requirements.

Worker's Compensation. DHS may disclose PHI as allowed by law to worker's compensation or like programs.

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

For Government Programs. DHS may use and disclose PHI for public benefits under other government programs. An example would be to figure out Supplemental Security Income (SSI) benefits.

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

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

For Reporting Death. DHS may disclose information of a deceased person to a coroner. DHS may also share information about a deceased person to a medical examiner or to a funeral director.

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

For Disaster Relief. Should there be a disaster, DHS may disclose information about you to any agency helping in relief efforts. DHS may share information about you to tell your family about your condition or location.

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

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

Your PHI privacy rights

When information is kept by DHS for its work as a public health agency, other state and federal laws govern the public health records. The public health records are not subject to the rights described below.

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

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

Right to Get a List of Disclosures. You have the right to ask DHS for a list of your PHI disclosures made after April 14, 2003. You must make the request in writing. This list will not include the times that information was disclosed for treatment, payment, or health care operations. The list will not include information provided directly to you or your family, or information that was sent with your authorization. If you request a list more than once during a 12-month period, you may be charged a fee.

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

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

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

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

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

How to contact DHS to use your privacy rights

To use any of the privacy rights listed above, you may contact your local DHS office. You may also contact the Governor's Advocacy Office at the address listed at the end of this notice. DHS may deny your request.

If DHS denies your request, DHS will send you a letter that tells you the reason. DHS will tell you how you can ask for a review of the denial.

How to file a privacy complaint or report a privacy problem

You may contact any of the people listed below if you want to file a privacy complaint. You may also contact them to report a problem with how DHS has used or disclosed your health information.

Your benefits will not be affected by any complaints you make. DHS cannot hold it against you if you file a complaint. DHS cannot hold it against you if you refuse to agree to something that you believe to be unlawful.

Oregon Department of Human Services

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

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

Office for Civil Rights

Medical Privacy Complaint Division
US Dept. of Health & Human Services
200 Independence Avenue SW
HHH Building, Room 509 H
Washington DC 20201

Phone: 1-800-627-7748
TTY: 1-866-788-4989
E-mail: OCRcomplaint@hhs.gov

For more information on this Notice of Privacy Practices

You can contact the DHS Privacy Officer if you have any questions about this notice. You can contact the DHS Privacy Officer if you need more information on privacy.

Oregon Department of Human Services

Privacy Officer
500 Summer St NE, E24
Salem, OR 97301

Phone: 503-945-5780 (Salem)
Fax: 503-947-5396 (Salem)
E-mail: DHS.privacyhelp@state.or.us

In the future, DHS may change its Notice of Privacy Practices. Any changes will apply to information DHS already has. It will also apply to information DHS receives in the future.

A copy of the new notice will be posted at each DHS site and facility. A copy of the new notice will be provided as required by law. You may ask for a copy of the current notice anytime you visit a DHS facility. You can also get a copy of the current notice online at

<<http://dhsforms.hr.state.or.us/forms/Served/DE2090.pdf>>.

My OHP phone list

DHS worker _____ Phone _____

OHP Client Advisory Services Unit (CASU) Phone 1-800-273-0557
TTY 1-800-375-2863
FAX 503-945-6898

OHP Premium Billing Office Phone 1-800-261-3317

Medical plan customer service _____ Phone _____

Doctor's name _____ Phone _____

Doctor's name _____ Phone _____

Doctor's name _____ Phone _____

Dental plan _____ Phone _____

Dentist's name _____ Phone _____

Mental health plan _____ Phone _____

Practitioner's name _____ Phone _____



Department of Human Services

Division of Medical Assistance Programs

500 Summer St NE, E35

Salem, OR 97301-1077

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Standard Mail
U.S. Postage Paid
Salem, OR
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