MEMBER HANDBOOK

610 Hawthorne Avenue SE, Suite 200
Salem, Oregon 97301

Toll Free: (800) 525–6800
Local: (503) 585–5205
TTY: (800) 735-2900 or 711
Fax: (503) 581-0043

www.capitoldentalcare.com
January 1, 2022

Special Assistance

Everyone has a right to know about Capitol Dental Care's programs and services. All members have a right to use our programs and services. We give free help when you need it. If have a special need or disability making it difficult for you to get dental care, call CDC Member Services.

We provide language and sign language interpreter services free of charge. You can request these services by calling CDC Member Services. Some examples of the free help we can give are:

- Sign language interpreters
- Spoken language interpreters for other languages
  - Certified and qualified, approved by OHA
- Written materials in other languages or other formats like braille or large print
- Audio and other formats
- Other auxiliary aids as needed

If you or your representative needs an interpreter at your dental visit, tell your provider's office. Tell them what language you need help in. Your provider will contact us to arrange an interpreter.

You can access an electronic version of this document at www.capitoldentalcare.com. Click on "Member Handbook" at the bottom of the page.

You may ask for a Member Handbook in the language and format of your choice at no cost to you. Every format will include the same information. You can ask that a free printed version of the Member Handbook be mailed to you. You may also contact the Member Service Department at 1-800-525-6800 to let us know you would like the Member Handbook sent to you by email. The Member Handbook will be sent within five (5) days of your request.

If you need help with any of these things, please contact Member Services:

- Call (800) 525-6800 or TTY (800) 735-2900 or 711
- Email members@capitoldentalcare.com

Alternate Formats

English: You can ask for an interpreter. Interpreter services are available for free if you need them. The Member Handbook is available in different languages, large print, computer disk, Braille, and audio tape. If you would like to request a different format or need assistance with the handbook, please call our Member Service Department at (503) 585-5205. The toll free number is (800) 525-6800, TTY (800) 735-2900.

Spanish: Puede solicitar un intérprete. Los servicios de interpretación están disponibles de forma gratuita si los necesita. El Manual para miembros está disponible en diferentes idiomas, letra grande, disco de computadora, Braille y cinta de audio. Si desea solicitar un formato diferente o necesita ayuda con el manual, llame a

nuestro Departamento de Servicios para Miembros al (503) 585-5205. El número gratuito es (800) 525-6800, TTY (800) 735-2900.

Russian: Вы можете попросить переводчика. Услуги переводчика предоставляются бесплатно, если они вам нужны. Справочник участника доступен на разных языках, крупным шрифтом, на компьютерном диске, шрифтом Брайля и на аудиокассете. Если вы хотите запросить другой формат или вам нужна помощь с руководством, позвоните в наш отдел обслуживания участников по телефону (503) 585-5205. Бесплатный номер: (800) 525-6800, телетайп (800) 735-2900.

Vietnamese: Bạn có thể yêu cầu thông dịch viên. Dịch vụ thông dịch viên được cung cấp miễn phí nếu bạn cần. Sổ tay Thành viên có sẵn bằng các ngôn ngữ khác nhau, bản in khổ lớn, đĩa máy tính, chữ nổi Braille và băng ghi âm. Nếu bạn muốn yêu cầu một định dạng khác hoặc cần hỗ trợ về sổ tay, vui lòng gọi cho Bộ phận Dịch vụ Thành viên của chúng tôi theo số (503) 585-5205. Số điện thoại miễn phí là (800) 525-6800, TTY (800) 735-2900.

Sight or Hearing Impaired

This handbook is available in large print and audio.

If need phone relay assistance, call the Oregon Telecommunication Relay Service. This service is offered 24 hours a day at no cost to you. Dial TTY/Voice (800) 735-2900 or 711. Calls are confidential. Long distance calls are billed to your phone.

If you need an ASL interpreter for a dental appointment let your dentist know or call CDC member services so one can be arranged for you.

Unfair Treatment/Nondiscrimination

We must follow state and federal civil rights laws. We cannot treat people (discriminate) unfairly in any program or activity because of a person's age, color, disability, gender identity, marital status, national origin, race, religion, sex, or sexual orientation.

Everyone has a right to enter, exit, and use buildings and services. They also have the right to get information in a way they understand. We will make reasonable changes to policies, practices and procedures by talking with you about your needs.

Do you think Capitol Dental Care or a provider has treated you unfairly? To report concerns or to get more information, please contact our Member Services Manager one of these ways:

Member Services Manager
610 Hawthorne Avenue SE, Suite 200
Salem, OR 97301
Phone: 800-525-6800 (TTY/TDD 711)
Fax: 503-581-0043
Email: members@capitoldentalcare.com
Complaint Form:
https://www.interdent.com/capitoldentalcare/members/member-rights/
You also have a right to file a complaint with the following entities:

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

- Bureau of Labor and Industries Civil Rights Division
  - Phone: (971) 673-0764
  - Email: crdemail@boli.state.or.us

- Mail: Bureau of Labor and Industries Civil Rights Division
  800 Oregon St., Suite 1045
  Portland, OR 97232

- U.S. Department of Health and Human Services Office for Civil Rights (OCR)
  - Web: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
  - Phone: (800) 368-1019, (800) 537-7697 (TDD)
  - Email: OCRComplaint@hhs.gov
  - Mail: Office for Civil Rights
    200 Independence Ave. SW
    Room 509F, HHH Bldg.
    Washington, DC 20201

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Welcome to
CAPITOL DENTAL CARE

Capitol Dental Care (CDC) is a dental care organization (DCO). We contract with the Oregon Health Authority (OHA). We also contract with coordinated care organizations (CCO). CDC delivers dental care to members covered on the Oregon Health Plan (OHP). CDC has worked with OHP members since 1994. CDC goal is to be "user friendly" and to do the right thing for our members.

Mission Statement

Capitol Dental Care is committed to preventing dental disease and improving the oral and systemic health of children and low income patients. We create access to quality care, use evidence-based methods and provide dental leadership within the communities we serve.

Contact Information

Address

- Capitol Dental Care
  610 Hawthorne Avenue SE, Suite 200
  Salem, OR 97301
- Office Hours: Monday–Friday from 7:00 a.m. to 6:00 p.m.

Capitol Dental Care is closed on these major holidays: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day.

Phone

- Phone: (800) 525-6800
- TTY: (800) 735-2900 or 711
- Fax: 503-581-0043

Internet

- Website: www.capitoldentalcare.com
- Member Services: members@capitoldentalcare.com
- Compliance: compliance@capitoldentalcare.com
- Other: admin@capitoldentalcare.com

IMPORTANT: Remember Email is not secure. It could be seen by others. You may wish to mail or fax personal health information rather than sending it by e-mail.

The Oregon Health Plan

The Oregon Health Plan (OHP) is a program that pays for the health care of low-income people in Oregon. The state of Oregon and the U.S. government's Medicaid program pay for it. It covers things like doctor visits, prescription drugs, hospital stays and dental care. It also covers mental health services, help with smoking, substance use disorder services, and getting to health care appointments. Some of the services covered by OHP are in the following table:

Doctor visits Prescriptions Help with addiction to cigarettes, alcohol and drugs	Hospital Stays Mental health services	Dental Care Free Rides to covered health care services

The OHP website has more details about what is covered. For more information, go to: oregon.gov/oha/healthplan

CCOs (Coordinated Care Organizations) are a type of managed care. The Oregon Health Authority (OHA) contracts with these private companies. They have been set up to manage health care for people on OHP. OHA pays the CCOs a set amount each month to provide the health care services.

Some OHP members do not get their services from a CCO. Providers are paid directly by OHA for each service provided. This is called fee-for-service (FFS), it is also called an open card. Native Americans, Alaska natives, people on both Medicare and OHP have a choice to be in a CCO, or on FFS. They can ask to change at any time. Any CCO member with a valid medical reason can ask to be on FFS. Contact CDC first to see if your issue can be resolved prior to requesting an open card through OHP. You may have questions or need help to choose your best

option. OHP Member Services can help you. Call them at (800) 273-0557.

Dental Self Care Plan

The American Dental Association says you should:

1. Brush your teeth twice a day.
2. Use fluoride toothpaste.
3. Floss between your teeth once a day.
4. Eat a balanced diet and limit snacks.
5. Visit your dentist regularly.
6. Get your teeth professionally cleaned.

Getting Dental Care

The steps for getting dental care are:

1. Be an OHP member assigned to CDC,
2. Find a participating dentist and
3. Get an appointment.

What To Do If You Are A New CDC Member

- Choose a Primary Care Dentist.
- Make an appointment with your Primary Care Dentist within your first 30 days with CDC

If you can't get in to see your Primary Care Dentist (PCD) during your first 30 days with CDC and you need prescriptions, medical supplies, or medical services right away, Care Coordination is available to help. They can help with the process of getting the needed items approved by your current or previous DCO. This includes help if you can't get a visit with your Primary Care Dentist during your first month with CDC. For more information about care coordination, call Member Services at 800-525-6800.

Oregon Health Identification Card

The Oregon Health Authority (OHA) will send you an OHP Identification Card. You should keep this card safe. Show it to your primary care

dentist (PCD) when you go to your appointments. If you lose your card, contact your Department of Human Services (DHS) worker.

CCO or CDC Identification Card

CDC or your CCO can also send you an Identification card. It contains our contact information. This card can be used at the dental office to show that you are on OHP.

Other Insurance – Third Party Liability

If you have other insurance coverage and are on CDC, let us know by calling OHP Customer Service or CDC Member Services at 1-800-525-6800.

If you have other insurance, you are required to provide your providers and Capitol Dental Care with this information. At a minimum this includes:

- The name of the third-party payer, or in cases where the third-party payer has insurance to cover the liability, the name of the policy holder;
- The member's relationship to the third-party payer or policy holder;
- The social security number of the third-party payer or policy holder;
- The name and address of the third-party payer or applicable insurance company;
- The policy holder's policy number for the insurance company; and
- The name and address of any third-party who injured the member.

Renewing Your Eligibility

You need to sign up for your OHP membership each year. You can do so by calling 1-800-699-9075 (TTY 711). If you need help visit go to OregonHealthCare.gov.

You should keep the same plans and providers that you already have. If there are changes that you did not want, you can request to be put back with the providers of your choice.

Disenrollment

You may ask to be disenrolled from CDC. A request to be disenrolled from a DCO needs to be done in person, on the phone or in writing by the member. For members who are not able to request disenrollment on their own, the request may be done by the member's representative.

The request to be disenrolled by a member or the member's representative shall be honored for the following reasons:

Without cause:

- Members may request to change their DCO enrollment within 30 calendar days of the Authority's automatic or manual enrollment error. If approved the change would happen during the next weekly enrollment cycle.

- Members may request to change their DCO enrollment within 90 calendar days of the initial DCO enrollment or during the 90 days following the date OHA sends the member notice of that enrollment, whichever is later if another plan is available in the member's service area. If approved, the change would happen during the next weekly enrollment cycle.

- At least once every 12 months thereafter.

- Members may request to change their DCO enrollment after they have been enrolled with that DCO for at least six months. If approved, the change would happen at the end of the month.

- A member may request to change their DCO enrollment at their OHP eligibility renewal, usually once per year.

- FBDE members and members who are American Indian/Alaska Native beneficiaries may change plans or disenroll to fee-for-service at any time.

Members may request to change their DCO enrollment at their OHP eligibility renewal time. The change would happen at the end of the month if approved. Members have another chance to ask for a DCO

disenrollment as listed below. The disenrollment would happen at the end of the month if approved.

With cause, at any time, as follows:

- The member moves out of Capitol Dental Care's service area; or

- Due to moral or religious objections the DCO does not cover the service the member seeks;

- When member needs related services to be performed at the same time and:
  - Not all related services are available within the provider network.
  - Your PCD or another provider determines that receiving the services separately would subject the member to unnecessary risk.

- Other reasons include: poor quality of care, lack of access to covered services, or lack of access to participating providers who are experienced in dealing with the specific member's health care needs. Examples of sufficient cause include:

  - The member moves out of the service area;
  - Services are not provided in the member's preferred language;
  - Services are not provided in a culturally appropriate manner;
  - It would be detrimental to the member's health to continue enrollment; or
  - For purposes of continuity of care.

CDC DCO Disenrollment Requests:

CDC may request to disenroll members for the following reasons:

- A member commits a fraudulent or illegal act related to participation in the OHP such as, permitting use of their medical ID card by others, altering a prescription, theft, or other criminal acts;

- A member is uncooperative or disruptive, except when such behavior is the result of the member's special health care needs or disability; or
- A member has committed an act of, or made a credible threat of, physical violence directed at a health care provider, the provider's staff, other patients, or the DCO staff, so that it seriously impairs the DCO's ability to furnish services to either this particular member or other members; or
- For other member-specific situations.

If OHA approves the disenrollment, the member will receive a notice to that effect and that they can file a grievance if they are dissatisfied with the process or request a hearing if they disagree with the decision to disenroll.

Other Information:
If you move out of the CDC service area, as soon as possible, you should contact either OHP's Virtual Eligibility Center at 800-699-9075 or Client Services Unit at 800-273-0557.

CDC cannot request to have a member disenrolled for the following reasons:

- An adverse change in the member's health status;
- Under or over-use of services;
- Disruptive or abusive behavior resulting from symptoms of a mental or substance use disorder or from any other disability; or
- Whose protected class, dental condition or history indicates probable need for substantial future dental services; or
- Physical, intellectual, developmental, or mental disability.

For more information or for questions about other disenrollment circumstances, temporary enrollment exceptions or enrollment exemptions, call CDC at 1-800-525-6800 or OHP Client Services at either 1-800-273-0557 or 800-699-9075.

Members will receive a written notice of disenrollment rights at least 60 days before the start of each enrollment period.

Primary Care Dentist

CDC is primarily responsible for coordinating your covered services and is a managed care dental plan. This means each member needs to have a primary care dentist (PCD). Your PCD will provide care or refer you to specialists for your dental care. If the covered service is not available by CDC's provider network, you will be able to access the covered service through a non-participating provider. In most cases, you must see providers that are in the CDC network. If a network provider is not available; your PCD will ask CDC if you can see an out-of-network provider. At no cost to you, we will work with your PCD to determine how soon you need to be seen and which out-of-network provider you can see.

Choosing a PCD

For the most part, you must use dental health care providers that are in our provider network. Our provider network is the group of dentists and other dental health care providers that we work with. You can choose from any provider in our provider network. This is called your freedom of choice. If you use a health care provider that is not in our network, you may have to pay for that appointment or service. Use the provider directory on our website for a list of dentists in your area located at: https://www.interdent.com/capitoldentalcare/members/list-of-providers/ Or you can ask CDC for a free copy of the provider list. Call the provider and let them know you are covered by CDC and would like to be a patient in their office. If the PCD you called is not accepting new patients, select another PCD. If you have difficulty finding a PCD or are new and need care prior to meeting with your PCD, call us for help. If you do not choose a PCD, one may be assigned to you. If you want to change your PCD, call CDC Member Services at 1-800-525-6800.

Changing PCD

CDC allows you to change your dentist twice a year. Carefully consider making changes during treatment. It is usually best to complete a dental treatment before changing to a new dentist. If you want to change call CDC for approval.

When CDC needs to let you know of changes in your PCD, the program, or our service sites that will affect you, we will notify you. CDC will

provide, "translated as appropriate," the notice of change at least 30 days before the effective date of that change, or 15 calendar days after receipt or issuance of the termination notice if the participating provider has not given CDC sufficient notification to meet the 30-day notice requirement.

Appointments

When you are ready to make an appointment, call your PCD. Keep your appointment and arrive on time. If you must cancel an appointment call the day before. If you miss too many appointments a provider might decide to no longer see you. If you need help getting to an appointment, call your OHP free ride service. You may call us for assistance if needed.

Oral Health Risk Screening

Shortly after you become a member with CDC, we will reach out to you a few times. We will do this by mail and phone call. We will ask you some questions about your oral health to complete an oral health risk screening. This helps us know about your needs.

CDC will conduct an oral health risk screening on an annual basis or sooner your condition changes. An initial oral health risk screening will be conducted within 90 days of the effective date of enrollment for all members and within 30 days of enrollment or referral for certain prioritized members. CDC may share results of your oral health risk screening with the member's Primary Care Dentist, OHA, and other MCEs serving the member to prevent duplication of activities.

Telehealth/Teledentistry

CDC is committed to providing access to its members through teledentistry when possible and appropriate. This means that you and the dentist are in different locations but you still receive care. The OHP covers teledentistry. Care that can be provided through teledentistry include dentist visit to triage a toothache, or nutritional counseling.

Our teledentistry program allows you to connect with Capitol Dental Care providers from home or anywhere you can be on your phone or computer. Ask your PCD if they do any services through teledentistry and

what the exact system requirements are. Examples of teledentistry platforms that may be used are: Zoom, FaceTime, Google Hangout, and Microsoft Teams.

Most dentists will be able to securely and safely connect to any laptop, computer web browser, smartphone or tablet. Teledentistry is secure. Your protected health information is protected just as if you had a face-to-face visit. If you have any questions about teledentistry call your PCD or Member Services at 1-800-525-6800.

Some dental providers use teledentistry and others are not doing so. You can find providers who offer this service in our Provider Directory. Providers listed in the Provider Directory with a 'Yes' in the telehealth column offer teledentistry services. You may also contact your PCD to learn what teledentistry options they offer. If your PCD does offer teledentistry, it is up to you whether to receive services this way. Providers are not allowed to limit members to only teledentistry services. Teledentistry services are culturally and linguistically appropriate. If you or a family member need an interpreter during this visit one can be arranged by calling Member Services at 1-800-525-6800.

Specialty Care

If you need care from a specialist your PCD will refer you. You may have to pay for a specialist's care if you go without your PCD' referral.

Keeping your appointment with a specialist is important. Their services are limited so a missed appointment could mean a long wait. The specialist can refuse to see you if you miss your appointment.

Care Coordination

Capitol Dental Care (CDC) has Care Coordination services available to members.

When you request Care Coordination services, a Care Coordinator will help you:

- Work with your Dental Care Organization (DCO), your Coordinated Care Organization (CCO) and other Managed Care Entities (MCE) as well as community support and social agencies.
- Find primary care dentists (PCD's) and other types of providers
- Access community support and social services
- Coordinate your care among your providers (dentist, physician) if you have:
    - a disability
    - several chronic conditions
    - special health care needs
    - and more

We will create a care plan that is based on your needs, so you get the care you need to reach your dental health goals.

If you have both Medicaid and Medicare, we can also help coordinate your care between them. We want to make sure you get the care and services you need.

CDC will ensure each provider furnishing services to members maintains and shares, as appropriate, a member's health record in accordance with professional standards.

No referral is needed for Care Coordination. Call Member Services at 800-525-6800, TTY 711. We will put you in touch with a staff member who is trained in Care Coordination. When you call, you will get instructions on how to contact your assigned Care Coordinator.

Second Opinions

CDC covers second opinions at no cost to you. If you want a second opinion about your treatment options, ask your dentist to refer you. You can also let CDC know that you want to see another provider. If you want to see a provider outside of our network, you or your provider will need to get CDC's approval first.

Rights of Minors (under age 18)

Someone under the age of 18 has special rights. There is a booklet called "Minor Rights: Access and Consent to Health Care" to help

explain these rights. The booklet is online at OHP.Oregon.gov. It tells the types of services that young people can get on their own. It explains how a minors' health care information may be shared.

Emergency Care

Dentists are available day and night, even on weekends and holidays. Urgent problems are things like severe infections and strong pain. If you don't know how urgent the problem is, call your dentist. If you can't reach your dentist's office or they can't see you soon enough, you can call us at 1-800-525-6800. We can help you talk to an on call dentist.

CDC ensures the availability of an after-hours call-in system adequate to triage urgent care and emergency calls from members or a member's long-term care provider or facility. CDC will return urgent calls appropriate to the member's condition but in no event more than 30 minutes after receipt. If information is not adequate to determine if the call is urgent, CDC will return the call within 60 minutes to fully assess the nature of the call. If information is adequate to determine that the call may be emergent in nature, CDC will return the call.

If you think that you have a medical emergency—call 911 or go to the nearest Emergency Room (ER). You don't need permission to get care in an emergency. An emergency might be chest pain, trouble breathing, bleeding that won't stop, broken bones, or an uncontrollable mental health issue. Sometimes ERs have a long and uncomfortable waits. It might take hours to see a doctor, so go there when you have to.

A mental health emergency is feeling or acting out of control. It might create a situation that could harm you or someone else. Get help right away. Do not wait until there is real danger. Call the Crisis Hotline, 911, or go to the ER.

Dental Emergency

A dental emergency is when you need care in the next 24 hours. It could be caused by something like a knocked out tooth. Or it might be because of infection in your mouth, unusual swelling or severe tooth pain. Severe pain keeps you awake at night or makes it hard to eat.

If you can't get help call us at 1-800-525-6800. We will help you talk with an on call dentist.

Treatment of an emergency dental condition is a covered service. You do not need pre-approval to get care for emergency dental services or post-stabilization services. You have the right to use any emergency center in the United States.

Urgent Dental Care

Urgent dental care is dental care that needs prompt but not immediate treatment. Examples of urgent dental care are a toothache, swollen gums and lost fillings. For urgent dental care call your dentist. If you cannot reach your dentist call CDC. You do not need pre-approval to get care for urgent dental services.

If You Need Care Out-of-town

If you need dental care when you are away from home—call your PCD. If you need urgent care, find a local dentist who will see you right away. Show them your OHP ID card. Ask them to call us to coordinate your care, to avoid being charged.

If you have a bill from an out-of-state provider, do not ignore it. You can call Member Services or OHA to discuss what you need to do.

Out-of-town Emergencies

If you have a real emergency when you are away from home, call 911 or go to the nearest Emergency Room. Your care will be covered until you are stable. For follow-up care after the emergency, call your PCP.

OHP covers emergency and urgent care anywhere in the United States, but not outside the US. That means OHP will not pay for any care you get in Mexico or Canada.

Care After an Emergency

Emergency care is covered until you are stable. Follow-up care to maintain or improve your condition once you are stable is covered by CDC but it is not considered an emergency. This care is called post-stabilization care. Post stabilization services can be obtained without pre-authorization. This care includes dental, behavioral and physical health. This care is available 24 hours a day and 7 days a week. CDC will pay for post-stabilization care provided by a dental provider, even if the dental provider is not in the CDC network. After you receive emergency treatment, call your Primary Care Dentist (PCD) to arrange for more follow-up care if you need it.

Native Americans/American Indians

American Indians and Alaska Natives can receive their care from an Indian Health Care Provider (IHCP) clinic or tribal wellness center.

If you see an IHCP that is not in CDC's network, they still must follow these rules:

- Only covered benefits will be paid.
- If a service requires a pre-approval, they must ask for it before providing the service.
- You may also call CDC Member Services for help.

Priority Populations

CDC makes every effort to provide care to all of its members as quickly and fully as possible. There are some members that may have increased needs, however. Members with special health care needs and members that get long-term services and supports, get direct access to care. They may receive direct access/standing referrals to a specialist as part of their treatment plans, depending on their situation. Those can include:

- Pregnant women;
- Members with special health care needs, including members who are older, blind, deaf, hard of hearing, or otherwise disabled. These members may also have complex/high health needs, multiple chronic conditions, behavioral health issues, or

substance use disorders. They may be receiving long-term services or supports.

Call Member Services at 1-800-525-6800 for direct access assistance.

Intensive Care Coordination

Intensive Care Coordination is like Coordinated Care services, but it is for our highest-need and most vulnerable members. Fee-for-service (FFS) members can reach KEPRO Care Coordination Team at (800)562-4620 for any Intensive Care Coordination needs.

Access Standards

Capitol Dental Care will abide by certain standards in providing access to services for its members. Members have timely access to services and providers taking into account the urgency of the need for services and within the acceptable travel time or distance standards in accordance with OAR 410-141-3515 and 410-141-3860.

We make sure that the services are available to you as close to where you live or where you seek care as possible.

- If you live in an urban area, you have access to providers within 30 miles, or 30 minutes of where you live. You live in an urban area if you live in or near a city.
- If you live in a rural area, you have access to providers within 60 miles, or 60 minutes of where you live. You live in a rural area if you do not live in or near a city.

CDC's appointment access standards are as follows:

Routine Care	Within 8 weeks
Urgent Care (Pregnant Members)	Within 1 week
Urgent Care (Children and Non-Pregnant Members)	Within 2 weeks
Emergency Care	Within 24 hours

Care for Pregnant Members	Within 4 weeks

CDC provides physical access, reasonable accommodations and accessible equipment for Medicaid enrollees with physical and mental disabilities. CDC has procedures in order to prevent duplication of services and activities.

Transportation Help

CDC can help you get transportation for non-emergencies. We have contact information for non-emergency medical transportation (NEMT) companies that can help you. People on the Oregon Health Plan (OHP or Medicaid) get help paying for rides to medical appointments. These are called medical rides. They are also called non-emergency medical transportation (NEMT). You will need to get approval before you go to your appointment. To get approval call the ride service below that serves your region.

County ▼	**CCO**	**Contact information**
Coos, Curry, Douglas, Jackson, Josephine, Klamath, Lake	None	TransLink (Rogue Valley Transportation District) - 541-842-2060 or 888-518-8160
Yamhill	None	Tri-County Med Link, 866-336-2906
Baker, Gilliam, Grant, Harney, Lake, Malheur, Sherman, Union, Wallowa, Wheeler	Eastern Oregon CCO	GOBHI Transportation Services - 877-875-4657
Coos, Curry, Douglas	Advanced Health	Bay Cities Brokerage - 877-324-8109
Curry, Douglas, Jackson, Josephine	AllCare	Ready Ride - 800-479-7920
Klamath	Cascade Health Alliance, PacificSource	TransLink - 888-518-8160
Clatsop, Columbia, Tillamook	Columbia Pacific CCO	NW Rides - 888-793-0439
Clackamas, Multnomah, Washington	Health Share of Oregon	Ride to Care - 855-321-4899
Jackson	Jackson Care Connect	TransLink - 888-518-8160

Benton, Lincoln, Linn	Intercommunity Health Network	Cascades West Ride Line (Oregon Cascades West Council of Governments) - 541-924-8738 or 866-724-2975 (TTY: 541-928-1775)
Crook, Deschutes, Jefferson	PacificSource	LogistiCare - 855-397-3619
Hood River, Wasco	PacificSource	LogistiCare - 855-397-3617
Lane	PacificSource	RideSource (Lane Transit District) - 541-682-5566 or 877-800-9899
Marion, Polk	PacificSource	LogistiCare - 844-544-1397
Douglas, Lane, Linn	Trillium	RideSource (Lane Transit District) - 541-682-5566 or 877-800-9899
Douglas	Umpqua Health Alliance	Bay Cities Brokerage - 877-324-8109
Polk, Washington, Yamhill	Yamhill Community Care	Well Ride - 844-256-5720
Clackamas, Multnomah, Washington	Trillium	MTM - 877-583-1552
Crook, Deschutes, Jefferson	None	Cascades East Ride Center (Central Oregon Intergovernmental Council) - 541-385-8680 or 866-385-8680
Clatsop, Columbia, Tillamook	None	NW MedLink - 833-585-4221
Lane	None	RideSource (Lane Transit District) - 541-682-5566 or 877-800-9899
Benton, Lincoln, Linn	None	Cascades West Ride Line (Oregon Cascades West Council of Governm

You may qualify for mileage reimbursement for rides. The reimbursement comes from your CCO or Brokerage (ride service). Mileage reimbursement may require prior authorization. To request prior authorization, call your CCO or Brokerage first to request approval.

Transition of Care

If you are changing from another DCO to Capitol Dental Care, we will help make that transition as smooth as possible.

Care while you change plans:
Some members who change plans can still get the same services and see the same providers. This means care will not change when you switch DCO plans or move to/from Oregon Health Plan (OHP) fee-for-service to a DCO. If you have serious dental health issues, your new and old plans must work together to make sure you get the care and services you need.

Please call Member Services at (800) 525-6800 right away if you are a new CDC member coming from another DCO. We will help you see a dentist as soon as possible. We will also help you get any medications or supplies that you may need until you can see a dentist.

You will have access to dental services consistent with the access you previously had. If your current dentist is not part of the CDC network, you will be able to continue seeing your current provider for a period of time. You will be referred to appropriate dental providers that are in the CDC network. If you have any service authorizations from your previous DCO, we will honor those and get you the care you need. Learn more about this special type of continued care in our Transition of Care policy online at:
https://www.interdent.com/capitoldentalcare/members/member-rights/

Your Dental Benefits

Services need to be dentally necessary to be covered. Covered services are free of charge. Please call us if you have any questions regarding your dental benefits. Capitol Dental Care does not have any moral or religious objections to providing care. Capitol Dental Care will work with community partners to make sure you have access to covered services.

Dental Benefits	Approval / Referral?	Limits to Care
Exams, cleanings, x-rays	No approval/referral required	Once per year for most adults. Twice a year those under 21 and for pregnant women.
Basic restorative care (Fillings)	No approval/referral required	No limit.
Dentures and Partials	Yes, approval/referral required	Only available for qualifying members. Call for details.
Sealants	No approval/referral required	Every 5 years for children (16 and under) with permanent molars.
Stainless Steel Crowns	Yes, approval/referral required	For molars (back teeth) only, may require approval.
Extractions (removing teeth)	Approval required for wisdom teeth. May not be required for other extractions	Some extractions including wisdom teeth require approval. Extractions for orthodontic care are not covered.
Root Canal Therapy	Yes, approval/referral required	Yes, with limitations. Call for details.
Emergency and Urgent Care	No approval/referral required	No limit.
Medicine		Must be ordered by your CDC dentist. Must be on the State formulary

Prioritized List of Health Services

OHP does not cover everything. The Oregon law makers do not have enough money to provide services for every type of illness. So they use the money that is available to pay for the most effective services for selected sicknesses and diseases.

A list of these sicknesses and diseases is called the Prioritized List of Health Services. This list was developed by a committee called the Oregon Health Evidence Review Commission (HERC). The HERC is a group of doctors, nurses and others concerned about health care issues in Oregon. The Prioritized List of Health Services is located at: https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Prioritized-List.aspx

To create the first prioritized list of health services, the HERC held public meetings around Oregon to find out which health issues were important to Oregonians. The HERC used that information to rank all health care procedures in order of effectiveness. HERC members are appointed by the governor and meet regularly to update the list.

The list contains hundreds of diseases and conditions. Only some of them are covered by OHP due to funding. The cut-off line between what is covered and what isn't covered is called the Funding Line. Sometimes, conditions on the list (above the funding line) need to meet certain criteria to be covered. The conditions "below the line" usually are not covered by OHP, but there may be exceptions. For example, something below the line could be covered if you have an above the line condition that could improve if the below the line condition is treated. OHP covers reasonable services for finding out what's wrong. That includes diagnosing a condition that is not currently funded. If a health care provider decides on a diagnosis or treatment that's not funded, OHP will not pay for any more services for that condition. The OHP website has more details about the list at: http://www.oregon.gov/oha/healthplan

Please call CDC member services if you have questions about covered services or prior authorization requirements. Your dentist will discuss your treatment plan with you at the time of your visit. You may have to pay for appointments or services that are not covered. A covered

service is a service that we provide under the Oregon Health Plan program. All of the services listed in this handbook are covered services. Remember, just because a service is covered, does not mean that you will need it. You may have to pay for services if we did not approve it first.

Prescription Drugs

If your dentist gives you a prescription, take it to your pharmacy and show your OHP ID card and Capitol Dental ID card. They will help you in getting the drug.

Stop Smoking Programs

CDC can help you try to quit smoking. Call your dentist or Member Services to learn about services to help you quit.
You may also contact the Oregon Quit Line. Their numbers are (800) 784-8669 and TTY (877) 777-6534. The web site is www.quitnow.net/oregon. You can also visit www.capitoldentalcare.com to view our Tobacco Cessation policy.

Non-Covered Services

Your dentist should tell you if a service is not covered. Ask about your other choices. There may be times when you want to receive a service that is not covered. You will have to pay for these services. You will need to sign OHP form number 3165 (also called a waiver) before you receive care indicating you will be responsible for payment. See https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/he3165.pdf

There may be services from other providers such as hospitals or labs that are necessary for the service you want. You will have to pay for these services too. Be sure to find out what services are needed and what they will cost.

If you get a bill for a service that you thought was covered, contact CDC member services at (800) 525-6800. You do not have to pay for covered services provided by a CDC provider.

Balance billing is when a provider bills you for the balance remaining on the bill that CDC doesn't cover. This amount is the difference between

the actual billed amount and the amount CDC pays. This happens most often when you see an out-of-network provider (non-contracted provider). There are rules that protect you from balance bills or surprise billing.

A provider may only bill you when:
• You do not inform the provider you have CDC coverage.
• If the service is not covered under your benefits.

You must sign a OHP 3165 or 3166 form or an exact copy of those forms, provided by the provider, before you may be billed. These forms are only valid if the estimated fee you were presented does not change, and if you are scheduled to receive the service within 30 days of signing the form.

A provider cannot bill you when:
• When you missed an appointment.
• Services or treatments have been denied due to provider error.

If you receive a bill, call us right away. Many providers send unpaid bills to collection agencies and even sue in court to get paid. It is much more difficult to fix the problem once that happens. As soon as you get a bill for a service that you received while you were on OHP, you should:

- Call the provider, tell them that you were on OHP, and ask them to bill Capitol Dental Care.
- Call CDC Member Services at 1-800-525-6800. Let us know that a provider is billing you for an OHP service. We will help you get the bill cleared up.
- You can appeal by sending your dental provider and CDC a letter saying that you disagree with the bill because you were on OHP at the time of the service.

Grievances or Complaints

Help is Available

Let us know if you need help with any part of the grievance, appeal, and/or hearings process. We can also give you more information about how we handle grievances and appeals. Copies of our notice template are

also available. If you need help or would like more information beyond what is in the handbook contact Member Services at: 1-800-525-6800

Grievances
If you are not happy with Capitol Dental Care, your healthcare services, or your provider, you can complain or file a grievance. You have a right to file a grievance if you are not satisfied with any part of your care. We will try to make things better. Just call Member Services at: Phone: 1-800-525-6800 (TTY/TDD 711). Fax: 503-581-0043. Or in writing:

Capitol Dental Care
610 Hawthorne Avenue SE, Suite 200
Salem, OR 97301

A representative or your provider may file a grievance on your behalf, with your written permission to do so. We will look into your grievance and let you know what can be done as quickly as your health requires. This will be done within five business days from the day we got your grievance.

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

If you are unhappy with how we handled your grievance, you can share that with the Oregon Health Authority's Client Services Unit at 1-800-273-0557 or an Oregon Health Authority Ombudsperson at 1-877-642-0450.

Appeals
If we deny, stop, or reduce a service your provider has ordered, we will send you a written Denial of Service Request explaining why we made that decision. This notice is also known as a Notice of Adverse Benefit Determination. We will also let your provider know about our decision.

If your provider tells you that a service is not covered or that you will have to pay for a particular service, you can contact us and ask for a

Denial of Service Request. Once you have the notice, you can request an appeal.

Requesting an Appeal
If you disagree with our decision and would like us to change it you can request an appeal. You have a right to request an appeal.

If you have a representative, they may request an appeal for you with your written permission. Your provider may also appeal our decision if you give them permission in writing to do so. An appeal request can be made either orally or in writing.

To request an appeal either:

Call us at: Member Services at: Phone: 1-800-525-6800 (TTY/TDD 711).

or

Complete and send us the Request to Review a Healthcare Decision form (OHP 3302) attached to the original notice by Fax: 503-581-0043. Or by mail:

Capitol Dental Care
610 Hawthorne Avenue SE, Suite 200
Salem, OR 97301

Appeal Review
Once we get your appeal request, we will look at the original decision. A new doctor will look at your medical records and the service request to see if we followed the rules correctly. You can provide any more information you think would help us make our decision. Once that review is done, we will send you our decision notice in writing. This notice is called a Notice of Appeal Resolution. We will also attach a hearing request form in case you do not agree with the outcome.

Appeal Timeframes
You have 60 days from the date on the Denial of Service notice to file an appeal. Once we get your request, we have 16 days to make our decision for a standard appeal. If you need more time, or if we need more time to make a decision, we can extend the timeframe by 14 days. If we extend

the timeframe, we will do our best to let you know orally. We will always send a written notice to let you know why we needed more time. You have a right to file a grievance if you disagree with the extension.

Fast or "Expedited" Appeals & Timeframes

A fast or "expedited" appeal can be requested if you or your provider thinks that waiting for a standard appeal could seriously harm you. If you qualify for a fast appeal, we will make our decision as quickly as your health requires. We will take no more than 72 hours from the time we receive your appeal request. We will do our best to reach you and your provider by phone to let you know our decision. We will always send our decision in writing. If we need more information and it is in your best interest, we can extend the timeframe by up to 14 days. If we extend the timeframe, we will do our best to let you know orally. We will always send a written notice to let you know why we need more time. You have a right to file a grievance if you disagree with the extension.
If we deny your request for a fast appeal, we will do our best to call you and your provider to let you know. We will also send a written notice within two days.

Contested Case Hearings & Timeframes

If you disagree with our appeal decision or we went beyond the required timeframes to make our decision you can request a hearing with an Oregon Administrative Law Judge. It is your right to request a hearing. At the hearing, you can tell the judge why you do not agree with our decision about your appeal. The judge will make the final determination. Your representative, if you have one, or the provider who initially requested the appeal may also request a hearing on your behalf if they have your permission in writing.

You have 120 days from the date on the Notice of Appeal Resolution to request a hearing.
To request a hearing send the Request to Review a Healthcare Decision form (OHP 3302) attached to the notice we sent you to:

OHA-Medical Hearings
500 Summer St NE E49
Salem, OR 97301
Fax: 503-945-6035

Fast or "Expedited" Hearings

The hearings process takes time. If you need a fast or "expedited" hearing because waiting for a standard hearing could seriously harm you, be sure to note that on the Request to Review a Healthcare Decision form (OHP 3302). The Oregon Health Authority's Medical Hearings Unit will review your request for an expedited hearing. If the request is denied, you will get a letter within two days to let you know.

Representation in a Hearing

You have the right to have another person of your choosing represent you in the hearing, for example a friend, family member, lawyer, or your medical provider.

You also have the right to represent yourself if you choose. If you hire a lawyer you must pay their fees. For advice and possible no-cost representation, call the Public Benefits Hotline at 1-800-520-5292; TTY 711 (a partnership between Legal Aid of Oregon and Oregon Law Center). Information about free legal help can also be found at OregonLawHelp.com

Benefits and Services During the Appeal & Hearings Process

If we close or reduce a service or benefit you were already receiving, you can keep getting the full benefit during the appeal and hearings process. You have to let us know that you want the full service or benefit to continue when you request the appeal or hearing. You have 10 days from the date of the Notice of Adverse Benefit Determination or the Notice of Appeal Resolution letter to request that your benefits continue.

If our decision is upheld in the appeal or hearing process, you may need to pay for the service or benefit you received during that time. If our decision is reversed in the appeal or hearing, and you kept getting the benefit during that time, we will go back and pay for it.

If our decision is reversed in the appeal or hearing and you were not receiving the service or benefit, we will approve or provide the service or benefit as quickly as your health requires. We will take no more than 72 hours from the day we get notice that our decision was reversed.

Fraud, Waste and Abuse

Capitol Dental Care (CDC) is committed to preventing fraud, waste, and abuse. We comply with all applicable laws, including the Oregon False Claims Act and the federal False Claims Act. We're a community health plan, and we want to make sure that healthcare dollars are spent helping our members be healthy and well. We need your help to do that. If you think fraud, waste, or abuse has happened report it as soon as you can. You can report it anonymously. Whistleblower laws protect people who report fraud, waste, and abuse. You will not lose your coverage if you make a report. It is illegal to harass, threaten, or discriminate against someone who reports fraud, waste, or abuse.

Examples of Fraud, Waste and Abuse by a Provider:

- Your provider billing for services or medical equipment that you did not receive.
- Your provider charging you for services that are covered by your health plan.
- Your provider giving you a service you don't need based on your health condition.

Examples of Fraud, Waste and Abuse by a Member:

- Going to multiple providers for prescriptions for a medication already prescribed to you.
- Letting another person use your health care benefits.

Reporting Fraud, Waste, and Abuse

Report fraud, waste, and abuse to Capitol Dental Care. To report fraud, waste, and abuse contact:
Capitol Dental Care - Compliance Officer
610 Hawthorne Avenue SE, Suite 200
Salem, OR 97301
Phone: 800-525-6800 (TTY/TDD 711)
Fax: 503-581-0043

We will send each report of suspected fraud, waste, and abuse committed by a provider or a member to the appropriate state agency listed below.

For Reports of Fraud, Waste, and Abuse by a Provider:

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

Or

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

For Reports of Fraud, Waste, and Abuse by a Member:
DHS Fraud Investigation Unit
PO Box 14150
Salem, OR 97309
Hotline: 1-888-FRAUD01 (888-372-8301)
Fax: 503-373-1525 Attn: Hotline
https://www.oregon.gov/oha/FOD/PIAU/Pages/Report-Fraud.aspx

Your Health Records Are Private – Confidential

CDC will keep your dental records and other information about you private. You can request a copy of our confidentiality policy. Call member services at 1-800-525-6800. It is also on our website.

A law called the "Health Insurance Portability and Accountability Act (HIPAA)" also protects your records. There is a notice available to you called the "Notice of Privacy Practices". It explains how your information may be used. It also explains what must be done to keep your dental records private. To get a copy call CDC member services at 1-800-525-6800. It is also on our website at: Notice of Privacy Practices

Your provider only shares your health records with those who need to see them. They share information to help with your treatment or to get payment for services. You can ask for a list of everyone who received information about you.

You can decide who sees your health records. If there is someone you don't want to see your health records, please tell your provider in writing.

Your Right to Inspect and Copy Your Health Records

You and your legal representatives have the right to review and get a copy of your health and dental records. Your PCD has most of your records, so you can ask them for a copy. They may charge a reasonable fee for copies.

Right to Change Your Records

If you think that information in missing from your dental records or is not accurate you can ask to have it corrected. Send a letter explaining what you would like to have changed. Explain why it should be changed.

Provider Incentives

CDC does not reward our staff for denying requests for dental services. We do not have financial incentives for dentist that might cause them to give you less care. You have the right to ask about our financial arrangements with providers. To find out contact CDC Member Services. Capitol Dental Care makes approval (payment) decisions about your dental benefits. These decisions are based only on appropriate care and coverage guidelines and rules. CDC does not reward our staff for denying pre-approval requests. CDC does not reward providers for giving less care. You have the right to ask if CDC has special financial arrangements with our providers that can affect referrals and other services. To help serve members best some providers offer alternative (different) payment methods. Providers that reflect our priorities can be eligible for monetary incentives. To find out more about our provider payment arrangements, call CDC Member Services.

End-of-life Decisions and Advance Directives (Living Wills)

An Advance Directive, also called a Living Will, gives your providers instructions on how to care for you. Adults 18 years and older can decide about their own care. This includes refusing treatment. An Advance helps you decide your care before you need it.

If you were in a coma or so sick or injured that you couldn't talk it tells the doctors your wishes for care. If you don't want certain kinds of treatment like a breathing machine or feeding tube say so in your Advance Directive. If you are awake and alert your providers will listen to what you want.

Without an Advance Directive, your providers may ask your family what to do. If no one can tell them, they will give you standard medical treatment. This means the normal treatment for your condition. Some providers may not follow Advance Directives. Ask your providers if they will follow yours.

CDC follows all state and federal laws about Advance Directives. You can get an Advance Directive form from many providers and at most hospitals. You also can find one online at:
www.oregon.gov/dcbs/shiba/docs/advance_directive_form.pdf.
If you write an Advance Directive give copies to your family and your providers. Be sure to talk to them about it so they can follow your instructions.

You can cancel your Advance Directive at any time. To cancel it, ask for the copies back. Tear up the old copies. Or you can write CANCELED in large letters, sign and date them.

For questions or more information contact Oregon Health Decisions at (800) 422-4805 or (503) 692-0894, TTY 711.

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

Health Care Regulation and
Quality Improvement 800
NE Oregon St, #305

Portland, OR 97232

Email: Mailbox.hcls@state.or.us
Fax: (971) 673-0556
Phone: (971) 673-0540; TTY: (971) 673-0372

Declaration for Mental Health Treatment

You can decide the care you would want if you are ever unable to make clear decisions. To learn more contact your mental health professional. See also https://www.oregon.gov/oha/HSD/amh/forms/declaration.pdf.

OHP Ombudsperson

Have a problem or complaint with your dental coverage. There is help for you. Call 877-642-0450 or visit https://oregonlawhelp.org/resource/oregon-health-authority-ombudsperson

For a complete list of member rights and responsibilities, please refer to the Oregon Health Plan Client Handbook. You can ask for a copy by calling (800) 237-0557, TTY 711.

Your Rights

- Be treated with dignity and respect;
- Be treated fairly and file a complaint of discrimination if you feel you've been treated unfairly because of your:
  - Age
  - Color
  - Disability
  - Gender Identity
  - Marital status
  - Race
  - Religion
  - Sex
  - Sexual Orientation
- Be treated by your dentist the same way that others are treated
- Be encouraged to work with your care team, including providers and community resources appropriate to your needs;
- Choose where you go to get dental services. Choose your providers. Change those choices in accordance with the rules.

- To go to behavioral health or family planning services without being sent by a participating provider;
- Have a someone of your choice come with you when you need them as long as it isn't against clinical guidelines;
- Take part in deciding what treatment you will receive.
- Be given information about your condition and covered and non-covered services to allow an informed decision about proposed treatments;
- Be able to choose or refuse services except in cases where it is court ordered. Have the consequences of the choices explained to you.
- Receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency;
- Have written materials explained to you in a way you can understand them. To be informed about the coordinated care approach that affects you and how to use it.
- Receive services in the language you can understand and that is sensitive to your culture. To have these available as close to where you live as possible. If possible, have services in non-traditional settings for families of diverse communities and underserved populations;
- Receive timely access to care and services.
  - See OAR 410-141-3515 and OAR 410-141-3860.
- Receive oversight, care coordination and transition and planning management to ensure culturally and linguistically appropriate community-based care is provided in a way that serves you in as natural and integrated an environment as possible and that minimizes the use of institutional care;
- Receive the services needed to diagnose your condition;
- Receive personal care that provides you choice and maintains your dignity. Care that is appropriate and meets the standards of the dental profession.
- Have a consistent and stable relationship with a care team that is responsible for comprehensive care management;
- To have those who understand your language and culture assist you get access to and use you benefits;
- Receive your covered preventive services;
- Be able to get urgent and emergency services 24 hours a day, seven days a week without prior approval;

- Receive a referral to specialty providers when needed as provided for in policy.
- Have a clinical record kept showing your health condition, services received, and referrals made;
- Have access to your clinical record except for where it would be unlawful.
- Have your clinical record corrected or changed to be more accurate.
- Transfer of a copy of the clinical record to another provider;
- Create a statement of your treatment wishes. The statement can include the right to accept or refuse dental treatment and the right to execute directives and powers of attorney for health care established under ORS 127;
- Receive written notices before a denial of, or change in, a benefit or service level is made, unless a notice is not required by federal or state regulations;
- Be able to make a complaint or appeal and receive a response;
- Request a contested case hearing;
- Receive certified or qualified health care interpreter services
- Receive a notice that an appointment has been cancelled in a timely manner; and
- To not have restraint or seclusion used to make you do something or to punish you. To have the federal regulations on the use of restraints and seclusion followed.
- Receive help to use the health care delivery system.
- To get help to access community, state and social support services
- Share information with CDC electronically. You can choose to do this or not.
- Have access to the following:
  - certified or qualified health care interpreters
  - certified traditional health workers
  - community health workers
  - peer wellness specialists
  - peer support specialists
  - doulas
  - personal health navigators
  - others as needed.

You also have the right to request certain information including:

- the structure and operations of CDC
- requirements for CDC to provide access to covered services
- network adequacy requirements.

Your Responsibilities

- To help with finding a PCD.
- To treat the CDC team, your dentist, and clinic staff with respect.
- To be on time for appointments. To call in advance if you will miss or be late to an appointment.
- To get periodic exams and preventive services from your PCD.
- To use your PCD for care except in an emergency.
- To get a referral before going to a specialist.
- To only use urgent and emergency when care can't be provided in an office. To notify the PCD within 72 hours of an emergency.
- To give accurate information.
- To help get your medical records from other providers. To sign a release of information form when needed.
- To ask questions in order to understand your conditions and treatments.
- To use information to make decisions about treatment.
- To help create a treatment plan with the provider.
- To follow prescribed, agreed upon treatment plans.
- To tell the provider that your health care is covered under OHP before services are received. If needed, show your provider your Medical Card.
- To report a change of address or phone number.
- To report if you become pregnant and of the birth of your child.
- To report if any family members move in or out of the household.
- To report if there is any other insurance available.
- To pay for non-covered services.
- To assist your PCD pursue third party insurers available such as from an injury. To pay the PCD if you receive the benefits paid.
- To bring issues, complaints or grievances to the attention of CDC.
- To sign an authorization for release of medical information when needed for an administrative hearing.

Words to Know

Appeal
To ask a plan to change a decision you disagree with about a service your doctor ordered. You can write a letter or fill out a form explaining why the plan should change its decision; this is called filing an appeal.

Copay
An amount of money that a person must pay themselves for health services. Oregon Health Plan members do not have copays. Private health insurance and Medicare sometimes have copays.

Dental care organization (DCO)
OHP has local health plans that help you use your benefits. These plans are dental care organizations or DCOs. DCOs have dental providers who work together in your community.

Devices for Habilitation and Rehabilitation
Equipment to help you benefit from habilitation and/or rehabilitation therapy services or meet other clinical or functional needs. Examples include walkers, canes, and crutches, glucose monitors and infusion pumps, prosthetics and orthotics, low vision aids, augmentative communication devices, and complex rehabilitation technologies such as motorized wheelchairs and assistive breathing machines.

Durable Medical Equipment (DME)
Things like wheelchairs, walkers and hospital beds. They are durable because they last a long time. They don't get used up like medical supplies.

Emergency Dental Condition
Dental emergencies, according to the American Dental Association (ADA), "are potentially life threatening and require immediate treatment to stop ongoing tissue bleeding [or to] alleviate severe pain or infection." Conditions include uncontrolled bleeding; cellulitis or a diffuse soft tissue bacterial infection with intraoral or extraoral swelling.

Emergency Medical Condition
An illness or injury that needs care right away. This can be bleeding that won't stop, severe pain or broken bones. It can be something that

will cause some part of your body to stop working right. An emergency mental health condition is feeling out of control, or feeling like hurting yourself or someone else.

Emergency Transportation
Using an ambulance or Life Flight to get medical care. Emergency medical technicians (EMT) give care during the ride or flight.

ER and ED
Emergency room and emergency department, the place in a hospital where you can get care for a medical or mental health emergency.

Emergency Room Care
Care you get when you have a serious dental or medical issue and it is not safe to wait. This care happens in an emergency room (ER).

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

Excluded Services
Things that a health plan doesn't pay for. Services to improve your looks, like cosmetic surgery, and for things that get better on their own, like colds, are usually excluded.

Grievance
A complaint about a plan, provider or clinic. The law says MCEs must respond to each complaint.

Habilitation Service
Services and devices that teach daily living skills. Habilitation focuses on helping you or a family member get, keep or improve skills that you need for communication and daily activities. An example is speech therapy for a child who has not started to speak.

Health Insurance
A program that pays for health care. After you sign up for the program, a company or government agency pays for covered health services. Some insurance programs require monthly payments, called premiums.

Health Risk Screening
A survey will be conducted to assess the member's overall health and provide individual assistance to members needing additional help to address issues impacting health. The survey will ask the member about their emotional and physical health, behaviors, living conditions, and family history and the DCO will use this information to connect the member to resources and supports that will help the member's overall health.

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

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

Hospital Inpatient and Outpatient Care
Hospital inpatient care is when the patient is admitted to a hospital and stays at least 3 nights. Outpatient care is surgery or treatment you get in a hospital and then leave afterward.

Hospitalization
When someone is checked into a hospital for care.

Medicaid
A national program that helps with health care costs for people with low incomes. In Oregon, it is part of the Oregon Health Plan.

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

Medically Necessary
Services and supplies that are needed to prevent, diagnose or treat a medical condition or its symptoms. It can also mean services that are accepted by the medical profession as standard treatment.

Network
The medical, mental health, dental, pharmacy and equipment providers that a coordinated care organization (CCO) contracts with.

Network Provider
Any provider in a CCO's network. If a member sees network providers, the plan pays the charges. Some network specialists require members to get a referral from their primary care provider (PCP).

Non-Network Provider
A provider who has not signed a contract with the CCO, and may not accept the CCO payment as payment-in-full for their services.

Participating Provider
A provider the DCO chooses to have a contract with. If you see network providers, the DCO pays. Also called a "network provider."

Physician Services
Services that you get from a doctor.

Plan
A medical, dental, mental health organization or CCO that pays for its members' health care services.

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

Premium
The cost of insurance.

Prescription Drug Coverage
Health insurance or plan that helps pay for medications.

Prescription Drugs
Drugs that your doctor tells you to take.

Primary Care Provider or Primary Care Physician
Also referred to as a "PCP," this is a medical professional who takes care of your health. They are usually the first person you call when you have health issues or need care. Your PCP can be a doctor, nurse practitioner, physician's assistant, osteopath, or sometimes a naturopath.

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

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

Rehabilitation Services
Special services to improve strength, function or behavior, usually after surgery, injury, or substance abuse.

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

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

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

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