Parkland
Community Health Plan

2026–2027

CHIP/CHIP Perinate Newborn
Member Handbook



Service Area:

Collin
Hunt
Dallas
Ellis
Kaufman
Navarro
Rockwall

Member Services:
1-888-814-2352

ParklandHealthPlan.com

TEXAS Health and Human Services | CHIP

009_072826_01MH

Parkland Community Health Plan (PCHP)
CHIP and CHIP Perinate Newborn

CHIP Member Handbook – Children's Health Insurance Program 2026-2027

Parkland Community Health Plan covers CHIP/CHIP Perinate Newborn services in the following counties:

Dallas Service area
Dallas, Collin, Ellis, Hunt, Kaufman, Navarro, and Rockwall counties

Member Services:
1-888-814-2352

Parkland Community Health Plan

TEXAS Health and Human Services | CHIP

www.ParklandHealthPlan.com

Parkland Community Health Plan (PCHP) uses the services of Cognizant Technology Solutions (CTS). CTS is not the insurer or sponsor of PCHP.

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About Your Health Plan

Welcome to Parkland Community Health Plan

Important Numbers

In case of an emergency or crisis, please call 9-1-1 or your local emergency hotline.

PCHP Member Services Monday – Friday, 8 am – 5 pm (excluding state holidays) English and Spanish speakers available Interpreter services available for other languages	**Toll Free: 1-888-814-2352** After hours and weekends: • Leave a voice mail message and your call will be returned the next business day OR • Contact the Parkland 24-Hour Nurse Line: **1-800-357-3162** TTY: 7-1-1 or 1-800-735-2989
Parkland 24-Hour Nurse Line 24 hours a day, 7 days a week English and Spanish speakers available Interpreter services available for other languages	**Toll Free: 1-888-667-7890** or **Direct Line: 214-266-8766**
Behavioral Health and Substance Abuse Services 24 hours a day, 7 days a week English and Spanish speakers available Interpreter services available for other languages	**Toll Free: 1-844-603-1134**
Vision Services: Avesis Vision	**1-866-678-7113**
Health and Human Services Commission: CHIP Helpline:	**2-1-1**; pick a language and then press option 2 1-800-964-**2777**
Dental Services: ✓ DentaQuest ✓ MCNA Dental Plans ✓ UnitedHealthcare Dental	 **1-800-508-6775** **1-855-691-6262** **1-800-822-5353**

Introduction: Your CHIP Member Handbook

Welcome to Parkland Community Health Plan (PCHP)
Through Parkland Community Health Plan (PCHP) CHIP and CHIP Perinate Newborn, we are pleased to offer your child all the benefits offered in the State of Texas's Children's Health Insurance Program (or "CHIP") plus expanded and value-added benefits. Information on eligibility and benefits are included in this Member Handbook. You picked your child's doctor or clinic when you joined PCHP CHIP/CHIP Perinate Newborn Member plan. The doctor or clinic you picked is your child's Primary Care Provider (PCP) and will be your gateway to care for all of your child's healthcare needs.

We wrote this member handbook to answer most of your questions about Parkland CHIP/CHIP Perinate Newborn. We hope you read it right away and keep it in a handy place. Please feel free to call or write us if you have any questions or would like to make suggestions.

This handbook is a guide to help you know your/your child's Parkland CHIP/CHIP Perinate Newborn Member plan. If you have any questions about your/your child's benefits or what is covered, please refer to the benefits section of this handbook. If you cannot find the answer to your question(s) in this handbook, you can use our website **www.ParklandHealthPlan.com**, or call us at the toll-free number on your/your child's ID card. We will be more than happy to help you.

At PCHP, we have staff who can speak English or Spanish and are ready to help you at any time, day or night. We also have special services for people who have trouble reading, hearing, seeing, or speak a language other than English or Spanish. You can ask for the Member Handbook in audio, other languages, Braille or larger print, we will get it for you upon request at no cost within 5 business days. To get help, just call Parkland CHIP Member Services at **1-888-814-2352.**

Tips for members
- Keep this handbook and any additional handbook information for future use.
- Write your/your child's ID number(s) in the front of this book or other safe place.
- Always carry your/your child's ID card with you.
- Keep your/your child's primary care provider's name and number near the phone.
- Use the hospital emergency room (ER) only for true emergencies.

Questions or need help understanding/reading member handbook?
We have Member Advocates who speak English and Spanish who can help you understand this handbook. We also have services for people who have a difficulty reading, hearing, seeing, or speaking a language other than English or Spanish. You can ask for the member handbook in other languages, audio, Braille or larger print. If you need an audio version, we will get it for you. we will mail it to you. To get help, go to our website at **www.ParklandHealthPlan.com** or call us at the toll-free number on your or your child's ID card.

Plan information and resources online
Get information 24 hours a day, 7 days a week on our website at **www.ParklandHealthPlan.com.**

You can find information and answers to your questions without calling us.

The website allows you to:

- View health/wellness resources.
- View questions and answers about the CHIP Program.
- Search our provider directory to find Parkland CHIP/CHIP Perinate Newborn doctors and hospitals in your area.
- Get information on different health topics.

Provider directory resource
Our provider directory has a list of all types of network providers and their names, addresses, phone numbers, specialty, education, board certification, languages spoken, ages served and more. The latest directory is always at **www.ParklandHealthPlan.com**. You can call member services if you need help locating an in-network provider or if you'd like us to send you a printed copy.

PCHP Member Services Department

We are available to assist you by phone Monday through Friday from 8 am to 5 pm excluding state-approved holidays. You can reach us by calling **1-888-814-2352**. You can:

- Ask questions about how to access your benefits and covered services.
- Change your address or phone number.
- Change your primary care provider.
- Find out more about how to file a complaint.

In the case of an emergency or crisis, please call 911 or your local emergency hotline.

For assistance after hours or on weekends, you can contact our Nurse Line at **1-800-357-3162**. You can also leave a voice mail message, and your call will be returned the next business day. Call your primary care provider with questions about appointments, hours of service, or getting care after hours.

All information is available in both English and Spanish, and interpreter services are available upon request. For people who are deaf or hearing impaired, please call the Relay of Texas TTY line at **711** or **1-800-735-2989** and ask them to call the Parkland CHIP Member Services line.

If you have any questions or suggestions, please call us at **1-888-814-2352,** or you can write us at:

Parkland Community Health Plan
Attention: Parkland CHIP Member Services
PO Box 560307
Dallas, TX 75356

Behavioral Health Services

Support for Behavioral health needs (including mental health and substance use) are available 24 hours a day, 7 days a week at **1-844-603-1134** for CHIP. and CHIP Perinate Newborn members.

All information is available in both English and Spanish, and interpreter services are available upon request.

If your child has a medical or behavioral health emergency and needs care, please call **911** or go to the nearest hospital/emergency room. If you go the emergency room, call us at **1-888-814-2352** to let us know. You should also call your doctor to schedule a follow-up visit as soon as possible.

Certificate of credible coverage
If you need proof of your/your child's coverage to help you enroll you or your child with another insurance plan, please call us at 1-888-814-2352. We will be happy to help you with a certificate of credible coverage upon request. You can also write to:

Parkland Community Health Plan, Inc.
Attention: Member Services
PO Box 560307
Dallas, TX 75356

Renewal Process

How does renewal work?
It's important to renew your/your child's CHIP/Children's Medicaid coverage on time. If not, the coverage could end. In your tenth month of coverage HHSC will mail a renewal packet to you that contain an application with some of your information already filled in.

- Update information as needed.
- Fill in all the questions that have been left blank.
- Make sure to send in copies of at least one paycheck stub or other document showing each family member's income and expenses.
- Sign and date the application then send it in using the postage-paid return address envelope. Missing information or documents can cause a delay in working on your application.
- You can also renew online or fax in the information.

Call 2-1-1 or visit, **www.yourtexasbenefits.com** to get help renewing your coverage.

What do I have to do if I/my child move?
As soon as you have your new address, give it to HHSC by calling 2-1-1 or updating your account on YourTexasBenefits.com and call the PCHP CHIP Member Services Department at **1-888-814-2352**. Before you get CHIP services in your new area, you must call PCHP, unless you need emergency services. You will continue to get care through PCHP until HHSC changes your address.

Getting Started

Member Identification (ID) Cards

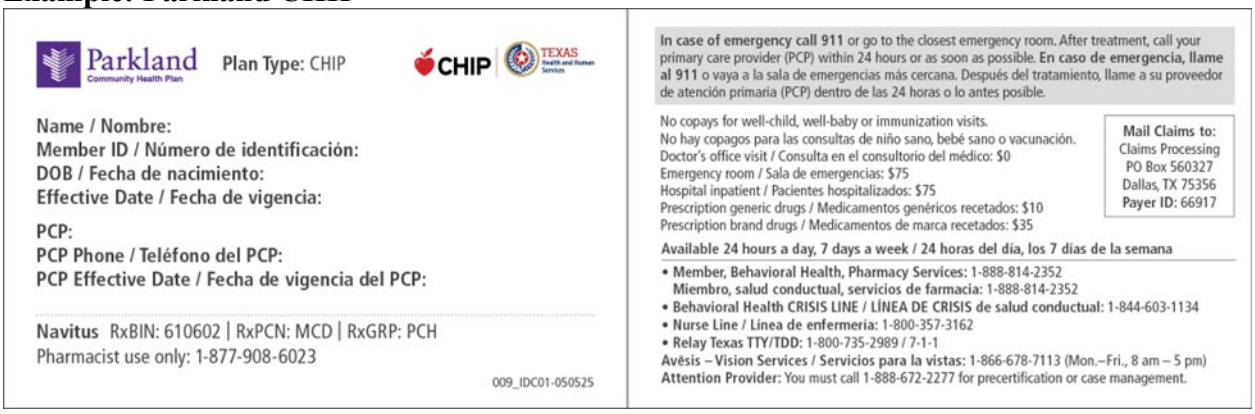
When you or your child is enrolled with us, you or your child will get an ID card from us. You or your child will not get a new ID card every month. If you call us to change your/your child's primary care provider or if your/your child's copay changes, you or your child will get a new ID card.

How to read your card: The ID card lists the name and phone number(s) of your/your child's primary care provider. It will show co-payment information, if you have to pay for services. The back of the ID card has important phone numbers for you to call if you need help.

Please make sure your/your child's information on his/her ID card is correct.

- Member: Last name, first name of member
- Member ID: Member identification number
- DOB: Member date of birth
- Effective date: Effective date of coverage with the health plan
- PCP: Name of primary care provider
- PCP phone: Primary care provider office phone number
- PCP Effective date: Effective date of coverage with the provider
- RxBIN: Bank identification number pharmacy uses to submit claims
- RxPCN: Processor control number pharmacy uses to submit claims
- RxGrp: Prescription group number pharmacy uses to identify the health plan

Example: Parkland CHIP



Parkland Community Health Plan **Plan Type:** CHIP

CHIP | TEXAS Health and Human Services

Name / Nombre:
Member ID / Número de identificación:
DOB / Fecha de nacimiento:
Effective Date / Fecha de vigencia:

PCP:
PCP Phone / Teléfono del PCP:
PCP Effective Date / Fecha de vigencia del PCP:

Navitus RxBIN: 610602 | RxPCN: MCD | RxGRP: PCH
Pharmacist use only: 1-877-908-6023

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In case of emergency call 911 or go to the closest emergency room. After treatment, call your primary care provider (PCP) within 24 hours or as soon as possible. **En caso de emergencia, llame al 911** o vaya a la sala de emergencias más cercana. Después del tratamiento, llame a su proveedor de atención primaria (PCP) dentro de las 24 horas o lo antes posible.

No copays for well-child, well-baby or immunization visits.
No hay copagos para las consultas de niño sano, bebé sano o vacunación.
Doctor's office visit / Consulta en el consultorio del médico: $0
Emergency room / Sala de emergencias: $75
Hospital inpatient / Pacientes hospitalizados: $75
Prescription generic drugs / Medicamentos genéricos recetados: $10
Prescription brand drugs / Medicamentos de marca recetados: $35

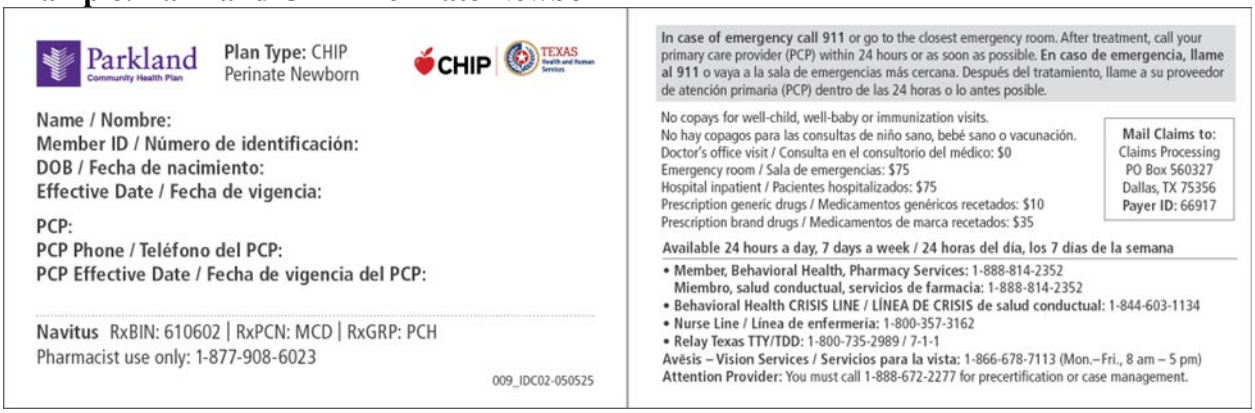
Mail Claims to:
Claims Processing
PO Box 560327
Dallas, TX 75356
Payer ID: 66917

Available 24 hours a day, 7 days a week / 24 horas del día, los 7 días de la semana

- **Member, Behavioral Health, Pharmacy Services:** 1-888-814-2352
  Miembro, salud conductual, servicios de farmacia: 1-888-814-2352
- **Behavioral Health CRISIS LINE / LÍNEA DE CRISIS de salud conductual:** 1-844-603-1134
- **Nurse Line / Línea de enfermería:** 1-800-357-3162
- **Relay Texas TTY/TDD:** 1-800-735-2989 / 7-1-1

Avēsis – Vision Services / Servicios para la vistas: 1-866-678-7113 (Mon.–Fri., 8 am – 5 pm)
Attention Provider: You must call 1-888-672-2277 for precertification or case management.

Example: Parkland CHIP Perinate Newborn



Parkland Community Health Plan **Plan Type:** CHIP Perinate Newborn

CHIP | TEXAS Health and Human Services

Name / Nombre:
Member ID / Número de identificación:
DOB / Fecha de nacimiento:
Effective Date / Fecha de vigencia:

PCP:
PCP Phone / Teléfono del PCP:
PCP Effective Date / Fecha de vigencia del PCP:

Navitus RxBIN: 610602 | RxPCN: MCD | RxGRP: PCH
Pharmacist use only: 1-877-908-6023

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In case of emergency call 911 or go to the closest emergency room. After treatment, call your primary care provider (PCP) within 24 hours or as soon as possible. **En caso de emergencia, llame al 911** o vaya a la sala de emergencias más cercana. Después del tratamiento, llame a su proveedor de atención primaria (PCP) dentro de las 24 horas o lo antes posible.

No copays for well-child, well-baby or immunization visits.
No hay copagos para las consultas de niño sano, bebé sano o vacunación.
Doctor's office visit / Consulta en el consultorio del médico: $0
Emergency room / Sala de emergencias: $75
Hospital inpatient / Pacientes hospitalizados: $75
Prescription generic drugs / Medicamentos genéricos recetados: $10
Prescription brand drugs / Medicamentos de marca recetados: $35

Mail Claims to:
Claims Processing
PO Box 560327
Dallas, TX 75356
Payer ID: 66917

Available 24 hours a day, 7 days a week / 24 horas del día, los 7 días de la semana

- **Member, Behavioral Health, Pharmacy Services:** 1-888-814-2352
  Miembro, salud conductual, servicios de farmacia: 1-888-814-2352
- **Behavioral Health CRISIS LINE / LÍNEA DE CRISIS de salud conductual:** 1-844-603-1134
- **Nurse Line / Línea de enfermería:** 1-800-357-3162
- **Relay Texas TTY/TDD:** 1-800-735-2989 / 7-1-1

Avēsis – Vision Services / Servicios para la vista: 1-866-678-7113 (Mon.–Fri., 8 am – 5 pm)
Attention Provider: You must call 1-888-672-2277 for precertification or case management.

How to use your card: Always carry your/your child's ID card with you when going to see the doctor. You will need it to get healthcare for you or your child. You must show it each time you or your child gets services.

How to replace your/your child's card if lost or stolen: Please call our Member Services department right away so we can send you another ID card.

Quick Tips for CHIP/CHIP Perinate Newborn Members

When should you go to the ER, Urgent Care, or call my Primary Care Provider?

See your Primary Care Provider

- When you are out of medicine
- If you have questions about your medicine
- When you have an earache, cough, cold, fever, sore throat
- When you have a minor injury, burn, or cut
- Routine asthma care
- When you need vaccines

Go to Urgent Care (if your doctor's office is closed)

- When you have an earache, cough, cold, fever, sore throat
- When you have a minor injury, burn, or cut

Go to the Emergency Room

- Having a hard time breathing
- Bleeding does not stop
- Poisoning
- Broken bones
- Asthma attack
- Passing out (fainting)
- Deep cuts or burns

Dental Checkups

Dental checkups should start at 6 months of age. Dental checkups should be done every six months unless the dentist needs to see your child more often. Your child's dental plan includes services that prevent tooth decay and fix dental problems. You do not need a referral form your doctor.

My child has a fever

Fever can be a sign of infection. Fever can be a reason to call the doctor, especially for babies under three months old. Call your provider if your child is not taking fluids, is very fussy, your child won't wake up, is vomiting or looks very ill.

Age	Temperature	What to do
1 to 2 months old	100.5	Call your PCP right away
3 to 4 months old	100.5	Call your PCP if the fever last more than 24 hours
over 4 months old	103	Call your PCP if the fever last more than 2 days after giving medicine

Your Out-of-Pocket Costs

What are co-payments? How much are they and when do I have to pay them?
The table below lists the CHIP co-payment by the amount your family makes. Co-payments are paid to the doctor or drugstore at the time of service. No co-payments are paid for well-child visits or immunizations. **Co-payments do not apply to Native Americans, or Alaska Natives.**

Co-pays do not apply on benefits for well-baby and well-child services, preventive services or pregnancy related assistance.

Your/your child's ID card lists the co-payments that you must pay. Show your/your child's ID card when you have an office visit, go to the ER, or have a prescription filled.

Note: Native Americans or Alaska Natives whose card show a co-payment requirement should call PCHP CHIP Member Services at 1-888-814-2352 to have their card corrected.

Co-payment table for CHIP members Effective 07/01/2022

Federal Poverty Levels (FPLs)	Office visits* **	Non-Emergency ER	Inpatient hospital co-pay***	Prescription drug (generic)	Prescription drug (brand name)	Cost sharing cap
At or below 151%	$5	$5	$35	$0	$5	5% of family net income**
Above 151% - including 186%	$20	$75	$75	$10	$25 for insulin $35 for all other drugs *	5% of family net income**
Above 186%- including 201%	$25	$75	$125	$10	$35	5% of family net income**

*Copays for insulin cannot exceed $25 per prescription for a 30-day supply, in accordance with Section 1358.103 of the Texas Insurance Code.
**Per 12-month term of coverage.
***No co-pay is applied for Mental Health/Substance Use Disorder (MH/SUD) residential treatment services. No co-pay is applied for MH/SUD office visits.

Enrollment Fees

Federal Poverty Levels (FPLs)	Charge
At or below 151%* **or otherwise exempt from copayments**	$0
Above 151% - including 186%	$35
Above 186%- including 201%	$50

*The federal poverty level (FPL) refers to income guidelines established annually by the federal government.
**Per 12-month term of coverage.

Cost sharing limit

What are cost sharing caps?

The member guide you got from CHIP when you enrolled includes a form to help you track your CHIP-related expenses. To make sure that you do not go over your cost-sharing limit, please list CHIP expenses on this form. The welcome letter in the enrollment packet tells you when you can mail the form back to CHIP. If you lose your welcome letter, please call CHIP at **1-800-964-2777**. They will tell you what your cost-sharing limit is. There are no co-payments required for CHIP Perinate Newborn members. When you reach your yearly cap per term of coverage, please send the form to the CHIP and they will let us know. We will send a new member ID card. This new card will show that no co-payments are due when your child gets services. If you need help understanding co-payments, please go to our website at **www.ParklandHealthPlan.com** or call us at the toll-free number listed on your/your child's ID card.

Provider billing

What if I get a bill from my doctor? Who do I call? What information will they need?

As a parent or guardian, you must pay for the co-payments for your child's care. If you feel that you should not have gotten a bill, or you need help to understand the bill, call us at the toll-free number listed on your child's ID card. We will help explain the bill to you. We can talk to the doctor's office for you to explain your child's benefits. We can also help you arrange for the bill to be paid. When you call us, please have your child's ID card and the doctor's bill with you. We will need information, so we can help you quickly.

Primary Care Providers

References to "you," "my," or "I" apply if you are a CHIP Member. References to "my child" apply if your child is a CHIP Member or a CHIP Perinate Newborn Member.

What is a primary care provider?

A primary care provider is your/your child's main doctor, nurse, or clinic that gives you most of your healthcare. This is called your "medical home." It will help you with all the medical care you or your child needs.

Your/your child's primary care provider can take care of routine medical problems. Sometimes you or your child might have a problem that needs to be handled by a specialist. The primary care provider will help coordinate and tell you how to make an appointment with a specialist. If you or your child needs to be admitted to a hospital, your primary care provider can arrange that for you or your child.

Our goal is your/your child's good health. We urge you or your child to see the primary care provider to get preventive care services within the next sixty (60) days or as soon as possible. This will help your doctor learn about you or your child so he or she can help you plan for you or your child's future health care needs. Getting started with your doctor can also help prevent delays in care when you or your child is sick.

Remember, you and the primary care provider are the most important members of your/your child's health care team.

Can a clinic be my/my child's primary care provider? (Rural Health Clinic/Federally Qualified Health Center)
Your/your child's primary care provider can be a clinic. Some of the doctors that you can also pick from to be your/your child's primary care providers are: Family doctors; pediatricians (for children); OB/GYNS (woman's doctor); general practitioners (GPs); advanced nurse practitioners (ANPs); Federally Qualified Health Clinics (FQHCs); and Rural Health Clinics (RHCs).

Please look at our provider directory to get more information on primary care providers. You must pick a primary care provider for you or your child who is in our network. You can get a copy of the directory on **www.ParklandHealthPlan.com** or by calling us at the toll-free number listed on your/your child's ID card.

Interpreter Services

Can someone interpret when I talk with my/my child's doctor? Who do I call for an interpreter?
Our Member Services staff speaks both English and Spanish. We have a language line if you do not speak English or Spanish. If you need an interpreter, call us at the toll-free number on your/your child's ID card. At the time of your call, we will get a language interpreter that speaks your language on the line. People that are deaf or hearing impaired can call the TTY line toll-free at **1-800-735-2989**.

How can I get a face-to-face interpreter in the provider's office? How far in advance do I need to call?
We can help you if you need an interpreter to go with you to your/your child's doctor's office. As soon as you know the date of your/your child's appointment, please call us at the toll-free number on your/your child's ID card. We ask for 72 hours advance notice of a need for an interpreter.

Changing Health Plans

Changing your or your child's health plan

For Parkland CHIP members

What if I want to change health plans?
You are allowed to make health plan changes:

- For any reason within 90 days of enrollment in CHIP;
- For cause at any time;
- If you move to a different service delivery area; and
- During your annual CHIP re-enrollment period.

Who do I call?
For more information, call CHIP toll-free at **1-800-964-2777**.

How many times can I change health plans?
You can change your health plan for any reason within 90 days of enrollment in CHIP and for cause at any time. You can change health plans if you move to a different services delivery area, and during your annual CHIP reenrollment period.

When will my health plan change become effective?
If you call to change your health plan on or before the 15th of the month, the change will take place on the first day of the next month. If you call after the 15th of the month, the change will take place the first day of the second month after that. For example:

- If you call on or before April 15, your change will take place on May 1.
- If you call after April 15, your change will take place on June 1.

Can PCHP ask that I get dropped from their health plan for non-compliance, etc.?
You or your child can be disenrolled from our plan if:

- Your child is no longer eligible for CHIP.
- You do not re-enroll yourself or your child at the end of the 12-month eligibility period
- You or your child permanently moves out of the service area.
- You or your child becomes enrolled in another health plan or has a change in health insurance status (i.e. coverage by employer insurance).
- You keep taking yourself or your child to the ER when you or your child does not have an emergency.
- You or your children show a pattern of disruptive or abusive behavior not related to a medical condition.
- You or your child misses many visits without letting your/your child's doctor know in advance.
- You let someone else use your/your child's ID card.
- You often do not follow your/your child's doctor's advice.

If you have any questions about your child's enrollment, call Member Services at 1-888-814-2352.

Member Safety

We are committed to educating our members about health safety. Research shows that most medical errors can be prevented by being an active participant in your/your child's health care. Here are some important tips:

- Be involved in every decision about your/your child's healthcare. You are more likely to know what you and your provider can do to improve and/or maintain your/ your child's health if you are involved with your/your child's healthcare.
- Ask questions. You have a right to question anyone who is involved with your/your child's care.
- Make sure your child's provider knows about all medications you or your child is taking, including prescriptions, over-the-counter medications and dietary supplements such as vitamins and herbs. Ask that these be written down in your/your child's file.
- Make sure your/your child's doctor knows if you or your child has any allergies or bad reactions to medications. This can help you avoid getting medications that could harm you or your child.
    - Ask for information about your/your child's medical treatment in a language you can understand. Be sure you know all the basics, such as medication dosage, drug interactions, possible side effects and why a particular medication and/or treatment is being recommended.

Understanding Your Coverage

Coverage for Newborns

If your baby is born to a family with an income above the Medicaid eligibility threshold, he or she will get the same coverage as a CHIP member beginning at birth. Your baby will get 12 months of continuous coverage through his or her health plan, beginning with the month of enrollment in the CHIP Perinatal program as an unborn child. For example, if an unborn baby is enrolled when the mother is 3 months pregnant, the baby will have 6 months of prenatal care and 6 months of full CHIP benefits as a CHIP Perinate Newborn member after birth.

Enrollment fees and copays don't apply to CHIP Perinate Newborn members but will still apply for any siblings enrolled in the CHIP program. The family will receive a CHIP renewal form in the 10th month of the child's CHIP Perinate Newborn coverage. The renewal form must be completed and submitted to continue benefits.

Benefits Overview

References to "you," "my," or "I" apply if you are a CHIP member. References to "my child" apply if your child is a CHIP member or a CHIP Perinate Newborn member.

What are my CHIP benefits?
Below is a list of some of the medical services you can get from CHIP. Some of your benefits have limits.

- Regular checkups and office visits
- Prescription drugs and vaccines
- Access to medical specialists and mental health care
- Hospital care and services
- Medical supplies, X-rays, and lab tests
- Treatment for special health needs
- Treatment for pre-existing conditions

Coverage for CHIP and CHIP Perinate Newborn members is the same except for copayments. Call Member Services toll free at **1-888-814-2352** for more benefit information.

What are the CHIP Perinate Newborn benefits? What benefits does my baby receive at birth?
If your baby is eligible as a CHIP Perinate Newborn, he or she will get the same coverage as a CHIP member beginning at birth except there are no co-pays while on CHIP Perinatal. Your baby will get 12 months of continuous coverage through his or her health plan, beginning with the month of enrollment in the CHIP Perinatal program as an unborn child.

You can call **1-800-964-2777** to learn more about Medicaid coverage. In the "Parkland CHIP and CHIP Perinate Newborn chart below.

How do I get these services/how do I get these services for my child?
You should see your/your child's primary care provider to ask about medical services. To learn more about how to obtain these or other services, please use the website (**www.ParklandHealthPlan.com**) or call us at the toll-free number on your/your child's ID card.

Are there any limits to any covered services?
There is no lifetime maximum on benefits; however, 12-month period or lifetime limitations do apply to certain services, as specified in the following.

Schedule of benefits
Parkland CHIP and CHIP Perinate Newborn provides services as outlined below. There is no lifetime maximum on benefits; however, 12-month enrollment period or lifetime limitations will apply to certain services, as specified in the following chart.

Covered Benefit	Limitations	Co-payments*
Inpatient General Acute and Inpatient Rehabilitation Hospital Services Services include: ▪ Hospital-provided Physician or Provider services ▪ Semi-private room and board (or private if medically necessary as certified by attending) ▪ General nursing care ▪ Special duty nursing when medically necessary ▪ ICU and services ▪ Patient meals and special diets ▪ Operating, recovery and other treatment rooms ▪ Anesthesia and administration (facility technical component) ▪ Surgical dressings, trays, casts, splints ▪ Drugs, medications and biologicals ▪ Blood or blood products that are not provided free-of-charge to the patient and their administration ▪ X-rays, imaging and other radiological tests (facility technical component) ▪ Laboratory and pathology services (facility technical component) ▪ Machine diagnostic tests (EEGs, EKGs, etc.) ▪ Oxygen services and inhalation therapy ▪ Radiation and chemotherapy	▪ Requires authorization for non-Emergency Care and care following stabilization of an Emergency Condition. ▪ May require authorization for in-network or out-of-network facility and Physician services for a mother and her newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by caesarian section.	Applicable level of inpatient co-pay applies per admission No co-pay is applied for Mental Health/Substance Use Disorder (MH/SUD) residential treatment services. No co-pay is applied for MH/SUD office visits.

Covered Benefit	Limitations	Co-payments*
▪ Access to DSHS-designated Level III perinatal centers or Hospitals meeting equivalent levels of care ▪ In-network or out-of-network facility and Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. ▪ Hospital, physician and related medical services, such as anesthesia, associated with dental care. ▪ Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: - dilation and curettage (D&C) procedures; - appropriate provider-administered medications; - ultrasounds; and - histological examination of tissue samples. ▪ Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: - cleft lip and/or palate; or - severe traumatic, skeletal and/or congenital craniofacial deviations; or - severe facial asymmetry secondary to skeletal defects, congenital syndromal condition and/or tumor growth or its treatment.		

Covered Benefit	Limitations	Co-payments*
▪ Surgical implants ▪ Other artificial aids including surgical implants ▪ Inpatient services for a mastectomy and breast reconstruction include: - all stages of reconstruction on the affected breast; - surgery and reconstruction on the other breast to produce symmetrical appearance; and - treatment of physical complications from the mastectomy and treatment of lymphedemas. ▪ Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12 -month period limit.		
Skilled Nursing Facilities (Includes Rehabilitation Hospitals) Services include, but are not limited to, the following: ▪ Semi-private room and board ▪ Regular nursing services ▪ Rehabilitation services ▪ Medical supplies and use of appliances and equipment furnished by the facility	▪ Requires authorization and physician prescription ▪ 60 days per 12-month period limit.	Co-pays do not apply
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: ▪ X-ray, imaging, and radiological tests (technical component)	▪ May require prior authorization and physician prescription	Applicable level of co-pay applies Applicable level of co-pay applies to prescription drug Co-pay does not apply to preventive services

Covered Benefit	Limitations	Co-payments*
▪ Laboratory and pathology services (technical component) ▪ Machine diagnostic tests ▪ Ambulatory surgical facility services ▪ Drugs, medications and biologicals ▪ Casts, splints, dressings ▪ Preventive health services ▪ Physical, occupational and speech therapy ▪ Renal dialysis ▪ Respiratory services ▪ Radiation and chemotherapy ▪ Blood or blood products that are not provided free-of-charge to the patient and the administration of these products ▪ Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility. ▪ Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: - dilation and curettage (D&C) procedures; - appropriate provider-administered medications; - ultrasounds; and - histological examination of tissue samples. ▪ Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: - cleft lip and/or palate; or		

Covered Benefit	Limitations	Co-payments*
- severe traumatic, skeletal and/or congenital craniofacial deviations; or - severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment. ▪ Surgical implants ▪ Other artificial aids including surgical implants ▪ Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include: - all stages of reconstruction on the affected breast; - surgery and reconstruction on the other breast to produce symmetrical appearance; and - treatment of physical complications from the mastectomy and treatment of lymphedemas. ▪ Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12- month period limit.		
Physician/Physician Extender Professional Services Services include, but are not limited to the following: ▪ American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations) ▪ Physician office visits, in-patient and outpatient services ▪ Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation	May require authorization for specialty services	Applicable level of co-pay applies to office visits Co-pay does not apply to preventative visits or to prenatal visits after the first visit

Covered Benefit	Limitations	Co-payments*
▪ Medications, biologicals and materials administered in Physician's office ▪ Allergy testing, serum and injections ▪ Professional component (in/outpatient) of surgical services, including: - Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care - Administration of anesthesia by Physician (other than surgeon) or CRNA - Second surgical opinions - Same-day surgery performed in a Hospital without an over-night stay - Invasive diagnostic procedures such as endoscopic examinations ▪ Hospital-based Physician services (including Physician-performed technical and interpretive components) ▪ Physician and professional services for a mastectomy and breast reconstruction include: - all stages of reconstruction on the affected breast; - surgery and reconstruction on the other breast to produce symmetrical appearance; and - treatment of physical complications from the mastectomy and treatment of lymphedemas. ▪ In-network and out-of-network Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.		

Covered Benefit	Limitations	Co-payments*
▪ Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation. ▪ Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Physician services associated with miscarriage or non-viable pregnancy include, but are not limited to: - dilation and curettage (D&C) procedures; - appropriate provider-administered medications; - ultrasounds; and - histological examination of tissue samples. ▪ Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: - cleft lip and/or palate; or - severe traumatic, skeletal and/or congenital craniofacial deviations; or - severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.		
Birthing Center Services Covers birthing services provided by a licensed birthing center	Limited to facility services (e.g., labor and delivery) Applies on to CHIP Members	Co-pay does not apply
Services rendered by a Certified Nurse Midwife or physician in a licensed birthing center.	CHIP Members: Covers prenatal services rendered in a licensed birthing center.	Co-pay does not apply

Covered Benefit	Limitations	Co-payments*
Covers prenatal, birthing, and postpartum services rendered in a licensed birthing center.	CHIP Perinate Newborn Members: Covers services rendered to a newborn immediately following delivery.	
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies Covered services include DME (equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of Illness, Injury, or Disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including but not limited to: ▪ Orthotic braces and orthotics ▪ Dental Devices ▪ Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses ▪ Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease ▪ Other artificial aids including surgical implants ▪ Hearing aids ▪ Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit. ▪ Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements.	▪ May require prior authorization and physician prescription ▪ $20,000 per 12-month period limit for DME, prosthetic devices and disposable medical supplies (implantable devices, diabetic supplies and equipment are not counted against this cap).	Co-pay does not apply
Home and Community Health Services	▪ Requires prior authorization and physician prescription ▪ Services are not intended to replace the CHILD'S	Co-pay does not apply

Covered Benefit	Limitations	Co-payments*
Services that are provided in the home and community, including, but not limited to: ▪ Home infusion ▪ Respiratory therapy ▪ Visits for private duty nursing (R.N., L.V.N.) ▪ Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.). ▪ Home health aide when included as part of a plan of care during a period that skilled visits have been approved. ▪ Speech, physical and occupational therapies.	caretaker or to provide relief for the caretaker. ▪ Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services. ▪ Services are not intended to replace 24-hour inpatient or skilled nursing facility services	
Inpatient Mental Health Services Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, including, but not limited to: ▪ Neuropsychological and psychological testing. ▪ When inpatient psychiatric services are ordered 1) by a court of competent jurisdiction pursuant to the Texas Health and Safety Code Chapters 573, Subchapters B and C, or 574, Subchapter D; or 2) as a condition of probation. ▪ The court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. These requirements are not applicable when the Member is considered incarcerated, as defined by UMCM Section 16.1.15.2.	▪ Requires prior authorization for non-emergency services ▪ Does not require PCP referral.	Applicable level of inpatient co-pay applies No co-pay is applied for Mental Health/Substance Use Disorder (MH/SUD) residential treatment services. No co-pay is applied for MH/SUD office visits.
Outpatient Mental Health Services Mental health services, including for serious mental illness, provided on an	▪ May require prior authorization. ▪ Does not require PCP referral.	Co-pay does not apply

Covered Benefit	Limitations	Co-payments*
outpatient basis, including, but not limited to: ▪ The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility. ▪ Neuropsychological and psychological testing ▪ Medication management ▪ Residential treatment services ▪ Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) ▪ Skills training (psycho-educational skill development ▪ When outpatient psychiatric services are ordered 1) by a court of competent jurisdiction pursuant to the Texas Health and Safety Code Chapters 573, Subchapters B and C, or 574, Subchapters A through G, Texas Family Code Chapter 55, Subchapter D; or 2) as a condition of probation. ▪ The court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. These requirements are not applicable when the Member is considered incarcerated, as defined by UMCM Section 16.1.15.2.	▪ A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 Tex. Admin. Code §412.303(48). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (that can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services.	
Inpatient and Residential Substance Abuse Treatment Services Inpatient and substance abuse treatment services include, but are not limited to: ▪ Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour	▪ Requires prior authorization for non-emergency services ▪ Does not require PCP referral.	Applicable level of co-pay applies No co-pay is applied for Mental Health/Substance Use Disorder (MH/SUD) residential treatment services.

Covered Benefit	Limitations	Co-payments*
residential rehabilitation programs. ▪ When inpatient and residential substance use disorder treatment services are required as: 1) a court order, consistent with Chapter 462, Subchapter D of the Texas Health and Safety Code; or 2) as a condition of probation ▪ The court order serves as a binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. ▪ These requirements are not applicable when the Member is considered incarcerated, as defined by UMCM Section 16.1.15.2.		No co-pay is applied for MH/SUD office visits.
Outpatient Substance Abuse Treatment Services Outpatient substance abuse treatment services include, but are not limited to: ▪ Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders. ▪ Intensive outpatient services ▪ Partial hospitalization ▪ Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training that consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day. ▪ Outpatient treatment service is defined as consisting of at least one to two hours per week	▪ May require prior authorization. ▪ Does not require PCP referral.	Co-pay does not apply

Covered Benefit	Limitations	Co-payments*
providing structured group and individual therapy, educational services, and life skills training. ▪ When outpatient substance use disorder treatment services are required as: 1) a court order, consistent with Chapter 462, Subchapter D of the Texas Health and Safety Code; or 2) as a condition of probation the court order serves as a binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. These requirements are not applicable when the Member is considered incarcerated, as defined by UMCM Section 16.1.15.2.		
Rehabilitation Services Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following: ▪ Physical, occupational and speech therapy ▪ Developmental assessment	▪ Requires prior authorization and physician prescription	Co-pay does not apply
Hospice Care Services Services include, but are not limited to: ▪ Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death ▪ Treatment services, including treatment related to the terminal illness, are unaffected by electing hospice care services.	▪ Requires authorization and physician prescription ▪ Services apply to the hospice diagnosis. ▪ Up to a maximum of 120 days with a 6 month life expectancy. ▪ Patients electing hospice may cancel this election at any time.	Co-pay does not apply

Covered Benefit	Limitations	Co-payments*
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services Health Plan cannot require authorization as a condition for payment for Emergency Conditions or labor and delivery. Covered services include: ▪ Emergency services based on prudent lay person definition of emergency health condition ▪ Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network providers ▪ Medical screening examination ▪ Stabilization services ▪ Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services ▪ Emergency ground, air and water transportation ▪ Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts	▪ Requires authorization for post-stabilization services	Applicable level co-pay applies
Transplants Covered services include: ▪ Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses.	▪ Requires authorization	Co-pay does not apply
Vision Benefit Covered services include: ▪ One examination of the eyes to determine the need for and prescription for corrective lenses	▪ The health plan may reasonably limit the cost of the frames/lenses. ▪ May require authorization for protective and polycarbonate lenses when medically	Applicable level of Co-pay applies to office visits billed for refractive exam

Covered Benefit	Limitations	Co-payments*
per 12-month period, without authorization ▪ One pair of non-prosthetic eyewear per 12-month period	necessary as part of a treatment plan for covered diseases of the eye.	
Chiropractic Services Covered services do not require physician prescription and are limited to spinal subluxation	▪ May require authorization for twelve visits per 12-month period limit (regardless of number of services or modalities provided in one visit) ▪ Requires authorization for additional visits.	Applicable level of Co-pay applies to chiropractic office
Tobacco Cessation Program Covered up to $100 for a 12-month period limit for a plan-approved program	▪ Requires authorization ▪ Health Plan defines plan-approved program. ▪ May be subject to formulary requirements.	Co-pay does not apply
Value-added Services	See "Extra Benefits" on page 32	Co-pay does not apply

What services are not covered?

Services that are not covered by CHIP are called "exclusions." The exclusions are listed below:

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system.
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (i. e. cannot be prescribed for family planning).
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles that are not required for the specific treatment of sickness or injury.
- Experimental and/or investigational medical, surgical or other health care procedures or services that are not generally employed or recognized within the medical community. This exclusion is an adverse determination and is eligible for review by an Independent Review Organization.
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court other than a court of competent jurisdiction pursuant to the Texas Health and Safety Code Chapter 573, Subchapters B and C Chapter 574, Subchapter D, or Chapter 462, Subchapter D and Texas Family Code Chapter 55, Subchapter D.
- Dental devices solely for cosmetic purposes.
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart.

- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise preauthorized by the health plan.
- Prostate and mammography screening.
- Elective surgery to correct vision.
- Gastric procedures for weight loss.
- Cosmetic surgery/services solely for cosmetic purposes.
- Out-of-network services not authorized by the health plan except for emergency care and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the health plan.
- Medications prescribed for weight loss or gain.
- Acupuncture services, naturopathy and hypnotherapy.
- Immunizations solely for foreign travel.
- Routine foot care such as hygienic care.
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails).
- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the member or the vendor.
- Corrective orthopedic shoes.
- Convenience items.
- Over-the-counter medications.
- Orthotics primarily used for athletic or recreational purposes.
- Custodial care (Care that assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice.
- Housekeeping.
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities.
- Services or supplies received from a nurse, that do not require the skill and training of a nurse.
- Vision training and vision therapy.
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a Physician/primary care provider.
- Donor non-medical expenses.

- Charges incurred as a donor of an organ when the recipient is not covered under this health plan.
- Coverage while traveling outside the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).

What are my prescription drug benefits?
CHIP covers most of the medicine your/your child's doctor says you need.

Primary Care Provider Visits

References to "you," "my," or "I" apply if you are a CHIP member. References to "my child" apply if your child is a CHIP member or a CHIP Perinate Newborn member**.**

What do I need to bring with me to my/my child's doctor's appointment?
You should take the following items with you when you go to your/your child's doctor's appointment:

- Parkland CHIP ID card
- Immunization (shot) records, and
- Paper to take notes on information you get from the doctor.

Regular visits to your primary care provider and dentist are important, even if your children are healthy. Well-child checkups are available at no cost to our members. Babies, children, and teens all need checkups. Follow this schedule:

Age Range	Target Ages
Birth to 1 year	2 weeks, 2 months, 4 months 6 months, 9 months
1 year to 4 years	12 months, 15 months 18 months, 24 months 30 months, 3 years, 4 years
5 years to 18 years	Annually within 30 days of birthday

Vaccines help protect your child from many infections. Infections can cause serious health problems. Your provider will give vaccines during your child's well-child exam, if needed. Be sure to bring your child's vaccine record to every visit. NOTE: Day care centers and schools require all children to be up to date on vaccines.

Changing Your/Your Child's Primary Care Provider

How can I change my/my child's primary care provider?
You can change your/your child's primary care provider by calling us at the toll-free number on your/your child's ID card. For a list of doctors and clinics, please see our provider directory. You can view this online at **www.ParklandHealthPlan.com**.

How many times can I change my/my child's primary care provider?
There is no limit on how many times you can change your or your child's primary care provider. You can change primary care provider by calling us toll-free at **1-888-814-2352.** or writing to:

Parkland Community Health Plan Attention: Member Services PO Box 560307
Dallas, TX 75356

When will a primary care provider change become effective?
If you change your/your child's primary care provider, you or your child will receive a new ID card. The new ID card will tell you the new primary care provider's name, address, phone number and date your/your child's new primary care provider will be effective. The primary care provider change will become effective the same day that you call us to change your/your child's primary care provider.

Are there any reasons why a request to change a primary care provider may be denied?
In some cases, your request to change your/your child's primary care provider can be denied. Your request can be denied if:

- The primary care provider you picked for you, or your child is not accepting new patients.
- The primary care provider you picked for you, or your child is no longer a part of Parkland CHIP/CHIP Perinate Newborn.

Can a primary care provider move me or my child to another primary care provider for non-compliance?
A primary care provider can request that you or your child pick a new primary care provider for the following reasons:

- You or your child often misses appointments and you have not called to let the primary care provider know.
- You do not follow advice from your/your child's primary care provider.

What if I choose to go to another doctor who is not my/my child's primary care provider?
You will need to go to your/your child's primary care provider for most health services or you might have to pay for the services.

What if my/my child's primary care provider leaves the PCHP Network?
If your/your child's doctor leaves the PCHP network, we will send you a letter telling you the new primary care provider we have chosen for you or your child. If you are not happy with the new primary care provider, call us at the toll-free number on your/your child's ID card and tell us the primary care provider you want. If you or your child is getting medically necessary treatments, you or your child will be able to stay with that doctor if he or she is willing to see you or your child. When we find a new primary care provider on our list who can give you or your child the same type of care, we will change your/your child's primary care provider.

Extra Benefits

What extra benefits does PCHP offer? (Restrictions and limitations may apply)
PCHP CHIP members get the following value-added services and extra benefits:

Category	Value Added Service	Limitations and Restrictions
24-Hour Nurse Line	Toll-free helpline staffed by nurses available 24 hours a day, 7 days a week.	❖ Must be a member.
Behavioral Health – Inpatient Follow-up Incentive Program	$30 reward (one per plan year) for behavioral health provider follow-up within 7 days after behavioral health hospitalization for ages 6 and older.	❖ Must be a member during hospital stay and follow-up; ❖ Follow-up within 7 days of discharge from behavioral health hospital; ❖ Follow-up must be completed with behavioral health provider; ❖ Must be ages 6 and older; ❖ $30 reward limit per year; ❖ Cannot earn with the 30-day reward for same hospitalization.
	$30 reward (one per plan year) for follow-up with behavioral health provider 8-30 days after hospitalization for ages 6 and older.	❖ Must be a member during hospital stay and follow-up; ❖ Follow-up within 8-30 days of discharge from behavioral health hospital; ❖ Follow-up must be completed with behavioral health provider; ❖ Must be ages 6 and older; ❖ $30 reward limit per year; ❖ Cannot earn with the 7-day reward for same hospitalization.

Category	Value Added Service	Limitations and Restrictions
Disease Management	$20 reward for completion of annual diabetic eye exam for members 18 years and older.	❖ Must be a member during exam; ❖ Must be diagnosed with diabetes; ❖ Must be ages 18 and older; ❖ $20 reward limit per year.
	$20 reward for completing an HbA1c blood test once every 6 months for members ages 18 and older.	❖ Must be a member during exam; ❖ Must be diagnosed with diabetes; ❖ Must be ages 18 and older; ❖ $40 reward limit per year.
	$50 reward annually for members who participate in PCHP's Diabetes Program 6 months in a row and achieve A1C of ≤8%.	❖ Must be a member; ❖ Must be enrolled in Diabetes program 6 consecutive months; ❖ $50 reward limit per year; ❖ Must achieve A1C of ≤8%.
Drug Store Services/Over-the-Counter Benefits	$20 reward for members who complete an annual Health Risk Assessment. Reward can be used for over-the-counter medicine not covered by CHIP.	❖ Must be a member; ❖ $20 reward limit per year.
Extra Help for Pregnant Women	$50 reward for members who get a postpartum checkup within 7-84 days of delivery.	❖ Must be member during checkup postpartum; ❖ Checkup must be within 7-84 days of delivery; ❖ $50 reward limit per year.
	Free meal service for postpartum members. Up to 10 free home delivered meals per pregnancy after hospital discharge.	❖ Must be a postpartum member; ❖ Up to 10 meal limit per year; ❖ CHIP members receive through 3 months postpartum.
	Free convertible car seat (one per plan year) for members who complete their first prenatal visit within the first trimester or within 42 days enrollment with Parkland Community Health Plan.	❖ Must be a member; ❖ Must have completed prenatal visit within first trimester or 42 days of enrollment; ❖ One convertible car seat per year.

Category	Value Added Service	Limitations and Restrictions
Extra Help for Pregnant Women	$25 reward (one per plan year) for pregnant members who complete 6 or more prenatal visits.	❖ Must be a member during visits; ❖ $25 reward limit per year; ❖ Must complete 6 or more prenatal visits prior to delivery.
Extra Vision Services	$100 allowance for members every 2 years toward upgrades on frames.	❖ Must be a member.
Gift Programs	$180 reward limit per child for members for the completion of each timely well-baby checkups: $120 for 6 visits by 15 months and $60 for 3 visits from 18 to 30 months.	❖ Must be a member during checkups ❖ $20 per checkup for up to 9 visits ❖ Must complete 6 visits by age 15 months and 3 visits from 18 to 30 months ❖ Must be age 0 through 30 months ❖ $180 reward limit per child
	$25 reward for getting one annual well-adolescent checkup from age 3 to 20 years.	❖ Must be a member during checkups; ❖ Must be age 3 through 20; ❖ $25 reward limit per year.
	$20 reward (one per plan year) for ADHD follow-up visit with prescribing doctor within 30 days of 1st prescription fill ages 6-12 years.	❖ Must be a member during visit; ❖ Visit must be with prescribing provider; ❖ Must be age 6 through 12; ❖ Must be diagnosed with ADHD; ❖ $20 reward limit per year.
	$20 reward annually for members who follow-up with their provider 2 times within 9 months of starting ADHD medication ages 6 to 12 years.	❖ Must be a member during visits; ❖ Two visits required in 9-month timeframe; ❖ Must be age 6 through 12; ❖ $20 reward limit per year.

Category	Value Added Service	Limitations and Restrictions
Gift Programs	$20 annual reward for members who refill their antidepressant medication prescription for 6 months in a row (11 and older.	❖ Must be a member while refilling medications; ❖ Must refill 6 months in a row; ❖ Must be age 11 and older; ❖ $20 reward limit per year.
Health and Wellness Services	$20 reward (one per plan year) for new members who complete a PCP visit within 90 days of enrollment.	❖ Must be a new member; ❖ Must complete visit within 90 days of enrollment; ❖ $20 reward limit per year.
	$20 reward for getting DTaP and Rotavirus vaccines by the second birthday, once per member.	❖ Must be a member; ❖ Must receive both vaccines by the second birthday; ❖ $20 reward, one time only.
	$30 reward for members who get an annual flu shot and report it to the health plan.	❖ Must be a member; ❖ $30 reward limit per year; ❖ Must complete self-attestation via the rewards portal or call center.
Healthy Play and Exercise Programs	Up to $100 annually for Boys & Girls Club membership for ages 6-18 years, where available.	❖ Must be a member; ❖ Must be ages 6 through 18; ❖ $100 reward limit per year; ❖ Participating locations only;
Help for Members with Asthma	Up to $60 reward annually ($15 per quarter) for members who refill their asthma-controlled medication 3 months in a row for ages 5 years and older.	❖ Must be a member; ❖ Must be age 5 and older ❖ Must be diagnosed with asthma; ❖ Medication must be asthma-controlled medication; ❖ $60 reward limit per year; ❖ Must refill medication continuously for 3 months.
Sports and School Physicals	One free sports physical with in-network PCP each school year for each covered member ages 5-19.	❖ Must be a member; ❖ Physical must be completed with member's assigned PCP; ❖ PCP must be in-network with PCHP; ❖ Must be ages 5 through 19; ❖ One free sports physical per year.

How can I get these benefits for my child?
You do not have to go to your/your child's primary care provider to get these services. If you have questions or need help with these services, visit the website (**www.ParklandHealthPlan.com**) or call us at the toll-free number on your/your child's ID card.

What health education classes does PCHP offer?
We work with our community partners to make available free and/or low-cost classes for parents and children. Some health topics include:

- Car seat safety
- Drug & alcohol awareness
- Immunizations
- Infant mortality
- Nutrition
- Oral health
- Physical fitness
- Poison safety
- Prenatal care
- Sexually transmitted diseases
- Smoking cessation
- Teen pregnancy prevention
- Vision awareness
- Weight management

Please call us to learn more. Please check with your doctor before you begin any new health or wellness program.

What other services or programs are available to me or my child?
There are other services that are not a part of CHIP. You or your child can also be able to get some of these services or programs:

- **Early Childhood Intervention (ECI) Program** – ECI gives services to children ages 0 to 3 years whose development is delayed. Some of the services for children are screenings, physical, occupational, speech and language therapy, and activities to help children learn better.
- **Mental Illness or Mental Retardation (MHMR) Case Management** – Coordination of care is given to help people get access to other needed services.
- **Supplemental Nutrition Program for Women, Infants and Children (WIC)** – WIC can help children under 5 years old and pregnant women to get nutritious food, nutrition education, and counseling.
- **Texas Information and Referral Network (TIRN)** – The phone number is 211. This is a free phone call which can help you find Health and Human Services in your local area.

Behavioral Health

How do I get help if I have mental health, alcohol, or drug use problems?
Parkland Community Health Plan manages mental health and substance use benefits. You do not need approval for individual, family, or group therapy. These visits do not have limits; however, your therapist may be asked to provide PCHP with clinical information after 30 sessions. Your therapist can request more visits if you need them. You can also get help with your medicine and/or go to the hospital if you are in trouble. You can get help for drug or alcohol problems as well as other services.

How do I get these services?
Parkland Community Health Plan (PCHP) can provide a list of all behavioral health treatment services available and can help connect you to a therapy provider if you do not have one.

PCHP is available 24 hours a day, 7 days a week to provide information and resources. If you are experiencing a behavioral health crisis, there are licensed therapists available to speak to. Just call **1-844-603-1134**

You can also search PCHP's online provider directory to locate providers in your area www.ParklandHealthPlan.com

Do I need a referral for this?
You do not need a referral from your primary care provider. You can self-refer to any PCHP in network behavioral health provider. You can also search PCHP online provider directory to locate providers in your area www.parklandhealthplan.com/members/provider-directory.

It is good for you to tell your primary care provider about all the doctors you or your child see. It is also important for your primary care provider and specialty providers, like your behavioral health treatment provider, to be able to share information about your treatment progress. This is called coordination of care. You can find more information about this on PCHP's member website: www.parklandhealthplan.com.

What behavioral health services are there?
There are many different types of services that can help you with mental health or substance use conditions. An assessment will help you and your provider understand your needs and decide what services are best for you. Examples of some behavioral health services are below, but there are others. For a complete list of services, please contact PCHP's Member Services at **1-888-814-2352**.

Medication Management is a service where your primary care provider or behavioral health provider prescribes medication to help treat symptoms of mental health or substance use disorders.

Outpatient therapy is a service delivered by a licensed clinician either one on one with the individual, in a group format or with a family unit. Usually, Outpatient therapy is delivered in short sessions between 45-60 minutes once or twice per week, unless additional treatment is needed

Mental Health Targeted Case Management are services designed to assist Members with gaining access to needed medical, social, educational, and other services and supports.

Residential services are highly intensive interventions where the member stays 24 hours / day, 7 days per week in a treatment facility to receive care. Individual, group and family therapy is provided along with other daily therapeutic interventions.

Inpatient Hospitalization provides intensive treatment in a hospital setting. Inpatient care is provided when a person's mental health or substance use condition poses significant risk to their health and safety.

If you lose Medicaid eligibility, you may be able to keep getting care from the Local Mental Health Authority and/or North Texas Behavioral Health Authority.

What about coverage of new technology?
We are always looking at new medical procedures and services to make sure you get safe, up to date and high-quality medical care. A team of doctors reviews new healthcare methods and decides if they should become covered services. Researched and studied investigational services and treatments are not covered services.

To decide if new technology will be a covered benefit or service, we will:

- Study the purpose of each technology.
- Review medical literature.
- Determine the impact of a new technology.
- Develop guidelines on how and when to use the technology.

Prescription Medications

For CHIP Members and CHIP Perinate Newborn Members

How do I get my/my child's medications?
CHIP covers most of the medicine your/your child's doctor says you need. Your/your child's doctor will write a prescription, so you can take it to the drugstore or may be able to send the prescription to the drugstore for you.

Exclusions include contraceptive medications prescribed only for the purpose to prevent pregnancy and medications for weight loss or gain.

You may have to pay a co-payment for each prescription filled depending on your income. There are no co-payments required for CHIP Perinate Newborn Members.

How do I find a network drug store?
You can find a network pharmacy in one of two ways.

- Visit our website at **www.ParklandHealthPlan.com**, and then search for a pharmacy in your area.
- Call Member Services toll-free at **1-888-814-2352**. Ask the representative to help you find a network pharmacy in your area.

What if I go to a drugstore not in the network?
Prescriptions filled at other pharmacies that are not in the PCHP CHIP network will not be covered. All prescriptions must be filled at a network pharmacy. Call Member Services at 1-888-814-2352 for help finding a pharmacy in our plan.

What do I bring with me to the drugstore?
You will need to bring the prescription your doctor wrote for you/your child. You will also need to show your/your child's PCHP CHIP/CHIP Perinate Newborn ID card.

What if I need my/my child's medications delivered to me?
Please visit the online pharmacy listing OR call Member Services at **1-888-814-2352** for pharmacies that offer delivery.

Do some medicines need to be prior approved – prior authorization?
PCHP must approve some medicines on our drug list before we cover them. We do this through prior authorization or Step-Therapy. Prior authorization is an approval that PCHP requires for certain services and medications.

What is Step-Therapy?
Some drugs are not approved unless another drug has been tried first. Step-Therapy (ST) coverage requires that a trial of another drug be used before a requested drug is covered.

When you/your child get a new prescription, ask your provider if we need to approve the medicine before you can get it. If we do, ask if there is another medicine you can use that does not need approval. When we need to approve your medicine, your provider must call PCHP for you. We will review the request to approve your medicine. If the pharmacist cannot reach PCHP to make sure it is approved, your pharmacist can give you a three (3) day temporary supply of the new prescription.

We will tell you in writing if we do not approve the request. We will also tell you how to start the appeal process.

What if I can't get the medication my/my child's doctor ordered approved?
If your/your child's doctor cannot be reached to approve a prescription, your child may be able to get a three-day emergency supply of your medication. Call PCHP Member Services at **1-888-814-2352** for help with your medications and refills.

What if I can't get the medication my/my child's doctor prescribed?
If the medicine your doctor feels you need isn't on our formulary and you cannot take any other medication except the one prescribed, your doctor may request an exception. Your doctor will need to fill out the request form and send us medical records to support the request for an exception. Your doctor will need to fill out the request form and send us medical records to support the request for an exception.

Who do I call if I have problems getting my/my child's medications?
If you have a problem getting your medications, call us at the toll-free number on your ID card.

What if I lose my/my child's medication(s)?
Lost or stolen medications are not a covered benefit. You may contact your pharmacy for an early refill and pay the cost of the medication.

What if I need /my child needs an over-the-counter medication?
The pharmacy cannot give you an over-the-counter medication as part of your/your child's CHIP benefit. If you need an over-the-counter medication, you will have to pay for it.

What if I need/my child needs birth control pills?
The pharmacy cannot give you/your childbirth control pills to prevent pregnancy. You/your child can only get birth control pills if they are needed to treat a medical condition.

What if I need/my child needs more than 34 days of a prescribed medication?
The pharmacy can only give you/your child as much of a medication as your child needs for 34 days. For any other questions, please call Member Services at **1-888-814-2352**.

Medically Necessary and Emergency Care

References to "you," "my," or "I" apply if you are a CHIP member. References to "my child" or "my daughter" apply if your child is a CHIP/CHIP Perinate Newborn member.

For CHIP/CHIP Perinatal Newborn Members

Covered services for CHIP Members, CHIP Perinate Newborn Members, and CHIP Perinate Members must meet the CHIP definition of "Medically Necessary." A CHIP Perinate Member is an unborn child.

What does medically necessary mean?
Medically Necessary means:

1. Healthcare Services that are:
    a. reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a member, or endanger life;
    b. provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's health conditions;
    c. consistent with healthcare practice guidelines and standards that are endorsed by professionally recognized healthcare organizations or governmental agencies;
    d. consistent with the member's diagnoses;
    e. no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
    f. not experimental or investigative; and
    g. not primarily for the convenience of the member or provider; and
2. Behavioral Health Services that:
    a. are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;
    b. are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral healthcare;
    c. are furnished in the most appropriate and least restrictive setting in which services can be safely provided;
    d. are the most appropriate level or supply of service that can safely be provided;
    e. could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered;
    f. are not experimental or investigative; and
    g. are not primarily for the convenience of the member or provider.

Routine medical care

What is routine medical care? How soon can I/my child expect to be seen?
Routine Medical Care is the non-emergency or non-urgent care that you or your child receives from their primary care provider, perinatal provider, or other healthcare provider. Your Primary Care Provider should be able to see you within two (2) weeks after you ask for the routine care appointment. If you or your child is seeing the doctor for a physical or wellness checkup, you/your child should be seen within 8 to 10 weeks after you ask for the appointment.

Call early to make your/your child's appointments. If you cannot keep your/your child's appointment, please call back to let the primary care provider know.

Urgent medical care

What is urgent medical care? How soon can I expect to be seen/how soon can I expect my child to be seen?
Urgent care is when you or your child has a medical problem that is not an emergency, including a cold, cough, small cuts, minor burns, or bruises. If you or your child needs urgent care, the primary care or perinatal provider should see you or your child within 24 hours after you ask for care.

You must first call your/your child's primary care provider or your perinatal provider at the number shown on your/your child's ID card. If you would like to speak to a nurse, you can call the Parkland 24-hour Nurse Line at **1-800-357-3162** or **214-266-8766**. The nurse can help decide if you or your child needs to go to the emergency room.

Emergency Care

For CHIP/CHIP Perinate Newborn members

What is an Emergency, an Emergency Medical Condition, and an Emergency Behavioral Health Condition?

Emergency care is a covered service. Emergency care is provided for Emergency Medical Conditions and Emergency Behavioral Health Conditions. No co-pay is applied for Emergency Mental Health/Substance Use Disorder services. Parkland Community Health Plan will not bill you for these services.

"Emergency Medical Condition" is a medical condition characterized by sudden acute symptoms, severe enough (including severe pain), that would lead an individual with average knowledge of health and medicine, to expect that the absence of immediate medical care could result in:

- placing the member's health in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part;
- serious disfigurement; or
- in the case of a pregnant CHIP member, serious jeopardy to the health of the CHIP member or her unborn child.

"Emergency Behavioral Health Condition" means any condition, without regard to the nature or cause of the condition, which in the opinion of an individual, possessing average knowledge of health and medicine:

- requires immediate intervention or medical attention without which the member would present an immediate danger to himself/herself or others; or
- renders the member incapable of controlling, knowing, or understanding the consequences of his/her actions.

What are Emergency Services or Emergency Care?

"Emergency Services" and "emergency care" mean health care services provided in an in-network or out-of-network hospital emergency department, free-standing emergency medical facility, or other comparable facility by in-network or out-of-network physicians, providers, or facility staff to evaluate and stabilize Emergency Medical Conditions or Emergency Behavioral Health Conditions. Emergency services also include any medical screening examination or other evaluation required by state or federal law that is necessary to determine whether an Emergency Medical Condition or an Emergency Behavioral Health Condition exists.

How soon can I/my child expect to be seen?

Regardless of which CHIP plan you are enrolled in, you should be seen right away if you or your child needs emergency care. Whether you are in or out of one of our service areas, we ask that you follow the guidelines below when you believe you or your child needs emergency care.

- Call **911** or the local emergency hotline or go to the nearest emergency facility. If a delay would not be harmful to your/your child's health, call your/your child's primary care provider. Tell your/your child's primary care provider as soon as possible after getting treatment.
- As soon as your/your child's health condition is stabilized, the emergency facility should call your/your child's primary care provider for information on your/your child's medical history.
- If you or your child is admitted to an inpatient facility, you, a relative or friend on your behalf should tell your/your child's primary care provider as soon as possible.
- Some good reasons to go to the ER are:
    - Danger of losing life or limb
    - Very bad chest pains
    - Poisoning or overdose of medicine
    - Choking or problems breathing
    - Possible broken bones
    - Uncontrolled diarrhea or vomiting
    - Heavy bleeding
    - Serious injuries or burns
    - Fainting
    - Suddenly not being able to move (paralysis)
    - Victim of violent attack (rape, mugging, stab, or gunshot wound)
    - You or your child has thoughts of causing harm to self or others
    - About to deliver a baby

Emergency Dental Care

For CHIP/CHIP Perinatal Newborn members

What do I do if I need/my child needs emergency dental care?
During normal business hours, call your child's main dentist to find out how to get emergency services. If your child needs emergency dental services after the main dentist's office has closed, call us toll-free at **1-888-814-2352**.

Post-Stabilization

What is post stabilization?
Post-stabilization care services are services covered by CHIP that keep the Member's condition stable following emergency medical care.

Follow-up care after emergency
You or your child might need follow-up care after going to the emergency room. If so, make an appointment with your/your child's primary care provider. Do not go back to the emergency room (unless it is an emergency). Do not go back to the doctor that treated you or your child at the hospital unless told to by your/your child's primary care provider.

After-Hours Care

How do I get medical care after my/my child's primary care office is closed?
If you or your child's primary care office is closed and you or your child gets sick at night or on a weekend and cannot wait to get medical care, call your/ your child's primary care provider for advice. Your/your child's primary care or another doctor is ready to help by phone 24 hours a day, 7 days a week. You may also call the 24-Hour Nurse Line **1-800-357-3162** or **214-266-8766** to help you decide what to do.

What if I get sick when I am out of town or traveling? What if my child gets sick when he or she is out of town or traveling?
If you/your child needs medical care when traveling, call us toll-free at **1-888-814-2352** and we will help you find a doctor. If you/your child need emergency services while traveling, go to a nearby hospital, and then call us toll-free at **1-888-814-2352.**

What if I am/my child is out of state?
If you/your child needs medical care when traveling, call us toll-free at **1-888-814-2352** and we will help you find a doctor. If you/your child need emergency services while traveling, go to a nearby hospital, then call us toll-free at **1-888-814-2352.**

What if I am/my child is out of the country?
Medical services performed out of the country are not covered by CHIP.

What if I need /my child needs to see a special doctor (specialist)?
Your/your child's primary care provider can send you to another doctor if you or your child needs a special type of care your primary care provider cannot give. Your/your child's primary care provider will tell you if you or your child needs to see a specialist. Some specialist services may require a prior authorization.

What is a prior authorization?
Prior authorization is an approval that Parkland Community Health Plan (PCHP) requires for certain services and medications. Some services need approval before they are given. The

provider who is treating you/your child should get this approval. You may ask your doctor or us if an approval is needed for a service or treatment.

What is a referral?
The doctor will talk to you about your/your child's needs and will help make plans for you to see the specialist that can provide the best care for you. This is called a referral. A referral is not a requirement for your PCHP plan of benefits.

What services do not need a referral?
The CHIP plan of benefits does not require referrals for any services; however, there are services that may need prior authorization.

How soon can I expect to be seen by a specialist/how soon can I expect my child to be seen by a specialist?
You should be able to go or take your child to see a specialist within 3 weeks for a routine appointment; within 24 hours for urgent care appointments.

What if my primary care provider wants me/my child to see a provider that is not in the PCHP network?
If your primary care provider wants you to see a provider who is not in PCHP provider network, he/she must request prior authorization from PCHP. You may go to a non-participating provider only if:

- The care is needed AND
- There are no PCHP providers to give the care AND
- PCHP has approved the care.

PCHP has the right to decide where you can get services when there is not a PCHP provider available to give the care. The non-participating provider who plans to give you care should assure prior authorization is obtained by your primary care provider to provide services. Call us at **1-888-814-2352** with any questions. This may include your doctor giving a reason for using a non-participating provider.

You may see any provider at any time in the case of an emergency or for family planning services

How can I ask for a second opinion?
You/your child can get a second opinion about the use of any health care service from a network provider. If a network provider is not available, you/your child can see an out-of-network provider. There is no cost to you for getting a second opinion. To learn more on how to ask for a second opinions please call us at the toll-free number on your ID card.

Other Member Services (Special Health Care Needs)

Who do I call if I have special health care needs and need someone to help me?
Case managers are ready to help you if you have special health care needs such as:

- ECI program participants.
- Pregnant women identified as high risk, including:
  -Pregnant Members age 35 and older or 15 and younger;

-Pregnant Members diagnosed with preeclampsia, high blood pressure, or diabetes;
-Pregnant Members with mental health or substance use disorder diagnoses; and
-Pregnant Members with a previous pre-term birth, as identified on the perinatal risk report

- Members with high-cost catastrophic cases or high service utilization, such as a high volume of ER or hospital visits.
- Members with mental illness and co-occurring substance use disorder diagnoses.

You can also have your healthcare provided by a specialist if you have special healthcare needs. If you have special healthcare needs and you need someone to help you, please call us at the toll-free number on your ID card to learn more.

Utilization Management

What is Utilization Management (UM) and what does it do for you?

The purpose of the utilization management program is to coordinate delivery of the best possible care to members and manage the use of healthcare resources to ensure an effective and efficient physical health care delivery system. The program is designed to ensure that the care delivered is appropriate, medically necessary, and aligns with the best and most accurate clinical practices.

Preservice review

Pre-Authorization: A decision by your health insurer or plan that a healthcare service (i.e., therapy, home health, private duty nursing), surgery, treatment plan, prescription drug, or durable medical equipment that you or your provider has requested, is medically necessary. This decision sometimes called prior authorization, prior approval, or pre-certification, must be obtained prior to receiving the requested service. Pre-authorization is not a guarantee of payment or that the services will be covered. Your doctor will submit pre-authorization request on your behalf.

A pre-authorization request can be expedited (urgent) or standard. An expedited (urgent) request is a request for medical care or services where the time frame for making the determination could seriously jeopardize the life, health or safety of the member or others. Conditions could include the member's psychological state, or in the opinion of a practitioner with knowledge of the member's medical or behavioral health condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

Expedited requests are processed within 72 hours after receipt of the request and standard requests are processed within three business days. A written notification is mailed to you and your doctor.

Urgent concurrent review

A request for coverage of medical care or services made while you are in the process of receiving care or services, even if your PCHP did not previously approve the care. All concurrent requests are considered urgent. Your doctor will submit the pre-authorization request on your behalf. A written notification is mailed to you and your doctor.

Post-service review

Your doctor is responsible for requesting authorizations for services prior to the service(s) being rendered. A post-service review, also known as a retrospective review, occurs upon request with

a determination rendered within 30 days of the request and contingent upon receipt of all necessary documentation needed to make the determination.

Filing an appeal

You have the right to ask for an appeal if you are not happy or disagree with the adverse benefit determination. PCHP will tell you in writing if we do not approve the request. We will also tell you how to start the appeal/complaint process, and you will get a timely response. An appeal is the process by which you or a person authorized to act on your behalf, including your doctor, requests a review of the adverse benefit determination. An appeal can be verbal or in writing. You or your doctor can send any additional medical information that supports why you disagree with the decision. You can call us at the toll-free number on your ID card and ask for an appeal. The Member Services Representative will write down the information and send it to you for review. A written appeal can be sent to:

Please submit your appeals and all supporting documentation as noted below:

Call: PCHP CHIP – 1-888-814-2352
Fax: 1-844-310-1823

Mail: Parkland Community Health Plan
Attn: Complaint and Appeals Team
P.O. Box 560347
Dallas, TX 75356

Email: PCHPComplaintsandAppeals@phhs.org

For more information, please review the member handbook or contact Member Services.
Parkland CHIP – 1-888-814-2352

Additional Health Care Programs

Early Childhood Intervention (ECI)

What is ECI?
ECI gives services to children ages 0 to 3 years whose development is delayed. Some of the services for children are screenings, physical, occupational, speech and language therapy, and activities to help children learn better.

Does my child need a referral for this?
You **do not** have to go to your child's doctor to get these services. If you have questions or need help with these services, call us at **1-888-814-2352.**

Where do I find an ECI provider?
If you have additional questions or need help with these services, please call us at **1-888-814-2352.**

Dental Services

CHIP/CHIP Perinate Newborn only

How do I get dental services for my child?

PCHP will pay for some emergency dental services in a hospital or ambulatory surgical center. PCHP will pay for the following:

- Treatment of a dislocated jaw.
- Treatment of traumatic damage to teeth and supporting structures.
- Removal of cysts.
- Treatment of oral abscess of tooth or gum origin.
- Treatment and devices for craniofacial anomalies.

PCHP covers hospital, physician, and related medical services for the above conditions. This includes services from the doctor and other services your child might need, like anesthesia or other drugs.

The CHIP medical benefit provides limited emergency dental coverage for dislocated jaw, traumatic damage to teeth, and removal of cysts; treatment of oral abscess of tooth or gum origin; treatment and devices for craniofacial anomalies; and drugs.

Your child's CHIP dental plan provides all other dental services, including services that help prevent tooth decay and services that fix dental problems. Call your child's CHIP dental plan to learn more about the dental services they offer.

Vision Services

CHIP/CHIP Perinate Newborn only

How do I get eye care services for myself/my child?
Avesis Vision will provide vision services like exams and glasses. Avesis Vision will help you or your child get the care he/she needs while coordinating with us. If you or your child needs vision services, please call Avesis Vision at **1-866-678-7113**.

Women's Health (Pregnancy and Childbirth)

Obstetric and gynecologic care

For CHIP and CHIP Perinate Newborn Members

What if I need/ my daughter needs OB/GYN care? Do I have the right to choose an OB/GYN?
You have the right to pick an OB/GYN for yourself/your daughter without a referral from your/your daughter's primary care provider. An OB/GYN can give you:

- One well-woman checkup each year
- Care related to pregnancy
- Care for any female medical condition
- Referral to special doctor (specialist) within the network

PCHP allows you/your daughter to pick an OB/GYN for you/your daughter, but this doctor must be in the same network as your/your daughter's primary care provider.

How do I choose an OB/GYN provider?
Check our provider directory to find an OB/GYN provider for you or your child. You can get a copy of the provider directory online at **www.ParklandHealthPlan.com** or call us at the toll-free number on your/your child's ID card for help in finding an OB/GYN.

If I don't choose an OB/GYN, do I have direct access?
You have the right to pick an OB/GYN from our network for yourself/your child without a referral from your primary care provider.

Will I need a referral?
You don't need a referral to see an OB/GYN. Your child can see only one OB/GYN in a month, but your child can visit the same OB/GYN more than once during that month, if needed.

While your child is pregnant, her OB/GYN can be her primary care provider. The nurses on our 24-hour Nurse Helpline can help you decide if she should see a primary care provider or an OB/GYN.

How soon can I/my daughter be seen after contacting my OB/GYN provider for an appointment?
If you or your child is pregnant, you/she should be seen within 2 weeks of enrollment/request or by the 12th week of your/her pregnancy. If you or your child is not pregnant, she should be seen within 3 weeks of asking for an appointment.

Can I/my daughter stay with an OB/GYN provider who is not with PCHP?
If you or your daughter is past the 24th week of pregnancy when you/she joins she will be able to stay under the care of your/her current OB/GYN/perinatal provider. If you/she chooses, you/she can pick an OB/GYN/perinatal provider who is in our network as long as the doctor agrees to treat you/her. We are available to help with the changes between doctors.

What if I or my daughter is pregnant? Who do I need to call?
Call us at the toll-free number on your/your child's ID card as soon as you know you or your daughter is pregnant. You/she needs to apply right away for Medicaid services. Your/your daughter's baby will be enrolled in Medicaid from birth up to a year old if you/she enrolls in Medicaid while you/ she is pregnant. (Not applicable to CHIP Perinate Newborn members.)

If you or your daughter does not enroll in Medicaid while you/she is pregnant, you/she will have to apply for coverage for your/her newborn after the baby is born. Please note that there could be a gap in coverage for your/her baby.

What other services/activities/education does PCHP offer pregnant women?
Case management
Case management is given to members who are pregnant. Our case managers help members to get the services that they might need. We can also help you get referrals when needed.

Prenatal education
We will mail a prenatal packet to all pregnant women. The packet has information about how to stay healthy during pregnancy and a list of childbirth classes and much more.

Complaints and Appeals

Submitting a Complaint

What should I do if I have a complaint? Who do I call?
We want to help. If you have a complaint, please call us toll-free at **1-888-814-2352** to tell us about your problem. You can file your complaint verbally or in writing at any time. A PCHP Member Service Representative can help you file a complaint. Most of the time, we can help you right away or at the most within a few days. PCHP take any action against you as a result of your filing a complaint.

Can someone from PCHP help me file a complaint?
The Member Service Representative can help you file a complaint. The Member Service Representative will write down your concern. You can also send a written complaint to:

Parkland Community Health Plan
Attention: Complaints and Appeals Department
PO Box 560347
Dallas, TX 75356
1-888-814-2352

How long will it take to process my complaint? What are the requirements and timeframes for filing a complaint?
There is no time limit for submitting a complaint, when we get the complaint from you, we will send you a letter within five (5) days to let you know that we got it. We will send you another letter within thirty (30) days from the date we got your complaint that will give you the results.

Do I have the right to meet with a complaint appeal panel?
If you are not satisfied with the complaint decision, you have the right to file a complaint appeal. Within five (5) days of getting your request for a complaint appeal, we will send you a letter to let you know that your complaint appeal came to us. The Complaint Appeal Panel will look over the information you submitted and discuss your/your child's case. It is not a court of law. You have the right to appear in front of the Complaint Appeal Panel at a specified place to talk about the written complaint appeal you sent us. When we make the decision on your complaint appeal, we will send you a response in writing within thirty (30) days after we get the complaint appeal.

If I am not satisfied with the outcome, who else can I contact?
If you are still not satisfied with the answer to your complaint, you can also complain to the Texas Department of Insurance by calling toll-free to **1-800-252-3439**. If you would like to make your request in writing send it to:

Texas Department of Insurance
Consumer Protection
PO Box 12030 – MC-CO-CPS
Austin TX 78711-2030

If you can get on the internet, you can send your complaint in an email to:
http://www.tdi.texas.gov/consumer/complfrm.html

Submitting an Appeal

What can I do if my doctor asks for a service or medicine for me/my child that's covered but PCHP denies or limits it?

If we deny or limit your doctor's request for a covered service for your/your child, you have the right to ask for an appeal. You can file your appeal verbally or in writing within 60 days of the notice we sent you saying the service or medicine was denied. You or your child's doctor can send us more information to show why you do not agree with the decision. You can call us and ask for an appeal. The Member Services Representative will write down the information and send it to you to look over. A written appeal can be sent to:

Parkland Community Health Plan
Attention: Appeals Department
PO Box 560347
Dallas, TX 75356

How will I find out if services are denied?

If your child's services are denied, you and your child's doctor will get a letter that tells you the reason for denial. The letter will also tell you how to file an appeal.

What are the timeframes for the appeal process?

You can appeal a decision to deny services within 60 days after you are informed of the decision. The timeframe for the resolution of the appeal will depend on what services have been denied. If you or your child is in the hospital or is already getting services that are being limited or denied, you can call and ask for an expedited appeal. The expedited appeal process is explained below.

For a standard appeal we will send you a letter within five (5) days of getting your request for an appeal to let you know that we got it. We will send all available information to a doctor who was not involved in making the first decision. You will get a written response on your appeal within thirty (30) days after we get the appeal.

When do I have the right to ask for an appeal?

If you don't agree with the decision made by us, you can ask us for an appeal. You do not have a right to an appeal if the services you asked for are not covered under the CHIP program or if a change is made to the state or federal law, which affects CHIP members.

Does my request have to be in writing?

Your request does not have to be in writing. You can call us to file your appeal. You will be asked to follow that call request with a written appeal. If you need help filing an appeal, see the section below. You can ask for an appeal by calling Member Services at 1-888-814-2352 this toll-free number listed on your/your child's ID card. We will write down what you tell us and send it to you to review.

Can someone from PCHP help me file an appeal?

You can get help in filing an appeal by calling us at the toll-free number listed on your/your child's ID card or writing to:

Parkland Community Health Plan
Attention: Appeals Department
PO Box 560347
Dallas, TX 75356

The Member Services Representative will listen to your appeal and tell you about the rules. The Member Services Representative will answer your questions and see that you are treated fairly.

Expedited Appeal Process

What is an emergency (expedited) appeal?
An Emergency (expedited) appeal is when the health plan has to make a decision quickly based on the condition of your health and taking time for a standard appeal could jeopardize your life or health.

How do I ask for an emergency (expedited) appeal?
You can ask for an expedited appeal by calling us toll-free **1-888-814-2352**. A written expedited appeal can be sent to:

Parkland Community Health Plan
Attention: Appeals Department
PO Box 560347
Dallas, TX 75356

Does my request have to be in writing?
Your request does not have to be in writing. You can ask for an expedited appeal by calling us at the toll-free number listed on your/your child's ID card.

What are the timeframes for an emergency (expedited) appeal?
The timeframe for resolution of your request of an expedited appeal will be based on your medical emergency condition, procedure, or treatment, but will not take more than 72 hours from your appeal request.

Who can help me in filing an emergency (expedited) appeal?
You can ask for an appeal by calling us at **1-888-814-2352** and asking for the Member Services Representative or writing to:

Parkland Community Health Plan
Attention: Appeals Department
PO Box 560347
Dallas, TX 75356

The Member Services Representative will listen to your appeal and tell you about the rules. The Member Services Representative will answer your questions and see that you are treated fairly.

What happens if PCHP denies the request for an emergency (expedited) appeal?
If you ask for an expedited appeal that does not involve an emergency, a hospital stay or services that are already being given, you will be told that the appeal review cannot be rushed. A written denial letter will follow within 2 days from the date of the decision. We will keep working the appeal and transfer it to the regular appeal timeframe and will respond to you within thirty (30) days from the time we got your appeal.

If you do not agree with this decision, you can ask for an outside review by an Independent Review Organization (IRO). The procedure to ask for a review by an IRO is explained below. You can also file a complaint with the Texas Department of Insurance by calling toll free at **1-800-252-3439** or writing to:

Texas Department of Insurance
Consumer Protection
PO Box 12030 – MC-CO-CPS
Austin TX 78711-2030
Fax: 512-475-1771
Web: **http://www.tdi.state.tx.us**
Email: **ConsumerProtection@tdi.state.tx.us**

Specialty Review Process

What is a Specialty Review?
The provider of record may request a specialty appeal, which requests that a specific type of specialty provider review the case.

How does a provider ask for a Specialty Review?
The provider of record can ask for a Specialty Review by writing to:

Parkland Community Health Plan
Attention: Complaints and Appeals
PO Box 560347
Dallas, TX 75356

What are the timeframes for a Specialty Review?
The provider of record must make the request within 10 days from the date the appeal was requested or denied.

The denial will be reviewed by a health care provider who works in the same or similar specialty as the condition, procedure or treatment under discussion for review.

This specialty review will be completed within 15 working days from receipt of the request.

Independent Review Organization (IRO)

What is an Independent Review Organization (IRO)?
An IRO is an organization that has no connection to us or the doctors that were previously involved in your treatment or decisions made by us about services that have not been given.

How do I ask for a review by an Independent Review Organization?
Standard IRO through the external review process
You or someone acting on your behalf or the provider of record (with members written consent) have the right to request a Standard External Review through MAXIMUS within 4 months after the date of your decision notification. To request the standard External Review, you would complete the HHS Federal External Review Request Form that will be enclosed with any denied appeal letter. Mail or fax the form along with this letter directly to MAXIMUS at:

MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534
Fax number: 1-888-866-6190

You can submit your request online at externalappeal.com under the "Request a Review Online" heading.

Expedited IRO through the external review process:
You or an individual acting on your behalf, or your provider of record (with written consent from the member) can ask that the External Review of the appeal be handled right away. If you believes waiting for a decision would cause you harm. To ask for an expedited external review:

- You can e-mail the request to FERP@maximus.com
- Call the Federal External review Process at 1-888-866-6205 x3326 or
- Selecting "expedited" when submitting the review request online

In urgent care situations, MAXIMUS Federal Services will accept a request for external review from a medical professional who knows about the claimant's condition. The medical professional will not be required to submit proof of authorization.

What are the timeframes for this process?

For standard External Review request: The MAXIMUS Federal Services examiner will contact PCHP when they receive the request for External Review. Within five (5) business days, PCHP will give the examiner all documents and information used to make the internal appeal decision. You or someone acting on your behalf, will receive written notice of the final External Review decision as soon as possible, but no later than 45 days after the examiner receives the request for an External Review.

For expedited or fast External Review request: The MAXIMUS examiner will give PCHP and you or the person filing on your behalf the External Review decision as quickly as medical circumstances require, but no later than within 72 hours of receiving the request.

You or someone acting on your behalf, will receive the decision over the phone, but MAXIMUS will also send a written version of the decision within 48 hours of the phone call notification.

Legal and Regulatory Information

Member Rights and Responsibilities

For CHIP/CHIP MEMBERS AND CHIP PERINATE NEWBORN MEMBERS

MEMBER RIGHTS

1. You have the right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals, and other providers.

2. Your health plan must tell you if they use a "limited provider network." This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. “Limited provider network” means you cannot see all the doctors who are in your health plan. If your health plan uses "limited networks," you should check to see that your child's primary care provider and any specialist doctor you might like to see are part of the same "limited network."

3. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.

4. You have a right to know how the health plan decides whether a service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.

5. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.

6. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.

7. If a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child's primary care provider. Ask your health plan about this.

8. Children who are diagnosed with special healthcare needs or a disability have the right to special care.

9. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months, and the health plan must continue paying for those services. Ask your plan about how this works.

10. Your daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her primary care provider and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.

11. Your child has the right to emergency services if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may

have to pay a copayment depending on your income. Copayments do not apply to CHIP Perinatal Members.

12. You have the right and responsibility to take part in all the choices about your child's healthcare.

13. You have the right to speak for your child in all treatment choices.

14. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.

15. You have the right to be treated fairly by your health plan, doctors, hospitals, and other providers.

16. You have the right to talk to your child's doctors and other providers in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.

17. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
18. You have a right to know that doctors, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
19. You have a right to know that you are only responsible for paying allowable copayments for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.
20. You have a right to make recommendations to PCHP's member rights and responsibilities.
21. You have the right to not be restrained or secluded when it is for someone else's convenience, is meant to force you to do something you do not want to do, or is to punish you.

MEMBER RESPONSIBILITIES

You and your health plan both have an interest in seeing your child's health improve. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.

2. You must become involved in the doctor's decisions about your child's treatments.

3. You must work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.

4. If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.

5. You must learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.

6. If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.

7. If your child has CHIP, you are responsible for paying your doctor and other providers copayments that you owe them. If your child is getting CHIP Perinatal services, you will not have any copayments for that child.

8. You must report misuse of CHIP or CHIP Perinatal services by healthcare providers, other members, or health plans.

9. You must talk to your provider about your medications that are prescribed.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services toll-free at 1-800-368-1019. You also can view information concerning the HHS Office of Civil Rights online at www.hhs.gov/ocr.

Parkland Community Health Plan Privacy Notice

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 notice took effect on September 16, 2013.

What do we mean when we use the words "health information?"
We use the words "health information" when we mean information that identifies you. Examples include your:

- Name
- Date of birth
- Healthcare you received
- Amounts paid for your care

How we use and share your health information?
Help take care of you: We may use your health information to help with your healthcare. We also use it to decide what services your benefits cover. We may tell you about services you can get. This could be checkups or medical tests. We may also remind you of appointments. We may share your health information with other people who give you care. This could be doctors or drugstores. If you are no longer with our plan, with your okay, we will give your health information to your new doctor.

Family and friends: We may share your health information with someone who is helping you. They may be helping with your care or helping pay for your care. For example, if you have an

accident, we may need to talk with one of these people. If you do not want us to give out your health information, call us.
are under 18 and don't want us to give your health information to your parents, call us. We can help in some cases if allowed by state law.

For payment: We may give your health information to others who pay for your care. Your doctor must give us a claim form that includes your health information. We may also use your health information to look at the care your doctor gives you. We can also check your use of health services.

Health care operations: We may use your health information to help us do our job. For example, we may use your health information for:

- Health promotion
- Case management
- Quality improvement
- Fraud prevention
- Disease prevention
- Legal matters

A case manager may work with your doctor. They may tell you about programs or places that can help you with your health problem. When you call us with questions, we need to look at your health information to give you answers.

Sharing with other businesses
We may share your health information with other businesses. We do this for the reasons we explained above. For example, you may have transportation covered in your plan. We may share your health information with them to help you get to the doctor's office. We will tell them if you are in a motorized wheelchair, so they send a van instead of a car to pick you up. We also may share your health information for these reasons:

- Public safety - To help with things like child abuse and threats to public health.
- Research - To researchers after care is taken to protect your information.
- Business partners - To people that provide services to us. They promise to keep your information safe.
- Industry regulation - To state and federal agencies. They check us to make sure we are doing a good job.
- Law enforcement - To federal, state and local enforcement people.
- Legal actions - To courts for a lawsuit or legal matter.

Reasons that we will need your written okay
Except for what we explained above, we will ask for your permission before using or sharing your health information. For example, we will get your permission:

- For marketing reasons that have nothing to do with your health plan.
- Before sharing any psychotherapy notes.
- For the sale of your health information.
- For other reasons as required by law.

You can cancel your permission at any time. To cancel, write to us. We cannot use or share your genetic information when we make the decision to provide your health care insurance.

What are your rights

- You have the right to look at your health information.
  - You can ask us for a copy of it.
  - You can ask for your medical records. Call your doctor's office or the place where you were treated.
- You have the right to ask us to change your health information.
  - You can ask us to change your health information if you think it is not right.
  - If we don't agree with the change you asked for, ask us to file a written statement of disagreement.
- You have the right to get a list of people or groups that we have shared your health information with.
- You have the right to ask for a private way to be contacted.
  - If you think the way we contact you is not private enough, call us.
  - We will do our best to contact you in a way that is more private.
- You have the right to ask for special care in how we use or share your health information.
  - We may use or share your health information in the ways we describe in this notice.
  - You can ask us not to use or share your information in these ways. This includes sharing with people involved in your healthcare.
  - We don't have to agree, but we will think about it carefully.
- You have the right to know if your health information was shared without your okay.
- We will tell you if we do this in a letter.

Call us toll-free at **1-888-814-2352** to:

- Ask us to do any of the things above.
- Ask us for a paper copy of this notice.
- Ask us any questions about the notice.

You also have the right to send us a complaint. If you think your rights were violated, write to us at:

Parkland Community Health Plan
P.O. Box 560307
Dallas, TX 75356

You also can file a complaint with the Department of Health and Human Services, Office of Civil Rights. Call us to get the address. If you complain and tell the Office of Civil Rights, you will not lose plan membership or healthcare services. We will not use your complaint against you.

Protecting your information

We protect your health information with specific procedures, such as:

- **Administrative**. We have rules that tell us how to use your health information no matter what form it is in - written, oral, or electronic.
- **Physical**. Your health information is secured and is kept in safe areas. We protect entry to our computers and buildings. This helps us to block unauthorized entry.
- **Technical**. Access to your health information is "role-based." This allows only those who need to do their job and give care to you to have access.

We follow all state and federal laws for the protection of your health information.

Will we change this notice?
By law, we must keep your health information private. We must follow what we say in this notice. We also have the right to change this notice. If we change this notice, the changes apply to all your information we have or will get in the future. You can get a copy of the most recent notice on our website at **www.ParklandHealthPlan.com**.

Nondiscrimination Notice

Parkland Community Health Plan follows Federal civil rights laws.
We don't discriminate against people and that means we won't exclude you or treat you differently because of these things:

Age	Color	Disability
National Origin	Race	Sex or Gender Identity

For people with disabilities or who speak a language other than English, we offer these services at no cost to you:

- Qualified sign language interpreters
- Written materials in large print, audio, electronic, and other formats
- Help from qualified interpreters in the language you speak
- Written materials in the language you speak

To get these services, call the toll-free Member Services number on your ID card:
Parkland Community Health Plan CHIP: 1-888-814-2352

Do you feel you didn't get these services, or we discriminated against you for reasons listed above? If so, you can file a grievance (complaint) with: Parkland Community Health Plan, P.O. Box 560347, Dallas, TX 75356, **1-888-814-2352** (TTY **711**), Fax: **1-844-310-1823** or PCHPComplaintsandAppeals@phhs.org.
If you need help filing? Call our Member Services for assistance.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

Mail: U.S. Department of Health and Human Services
200 Independence Ave. SW
Room 509F, HHH Building
Washington, DC 20201

Phone: 800-368-1019 (TTY/TDD 800-537-7697)
For a complaint form, visit https://www.hhs.gov/ocr/complaints/index.html

Reporting Fraud, Waste, or Abuse

Do you want to report CHIP waste, abuse or fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other healthcare provider, or a person getting CHIP benefits is doing something wrong. Doing something wrong could be waste, abuse or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for CHIP services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use a CHIP ID.
- Using someone else's CHIP ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

To report waste, abuse, or fraud, choose one of the following:

- You can report directly to your health plan:

Mail:	Parkland Community Health Plan Attention: SIU Coordinator PO Box 560307 Dallas, TX 75356-9005
Phone:	1-888-212-2579
Email:	PCHPSIU@phhs.org

- Call the OIG Hotline at **1-800-436-6184**;
- Visit **https://oig.hhsc.state.tx.us/** and click the red "Report Fraud" box to complete the online form.

To report waste, abuse or fraud, gather as much information as possible.

When reporting about a provider (a doctor, dentist, counselor, etc.) include:

- Name, address, and phone number of providers
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility, if you have it
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

When reporting about someone who gets benefits include:

- The person's name
- The person's date of birth, Social Security Number, or case number if you have it
- The city where the person lives
- Specific details about the waste, abuse, or fraud

Physician Incentive Plans

Your health plan cannot make payments under a physician incentive plan if the payments are designed to induce providers to reduce or limit medically necessary covered services to members. Right now, Parkland CHIP does not have a physician incentive plan.

Subrogation

What is subrogation?
We might ask for payment for medical expenses to treat an injury or illness that was caused by someone else. This is a "right of subrogation" provision. Under our right of subrogation, we reserve the right to get back the cost of medical benefits paid when another party is (or might be responsible) for causing the illness or injury to you. We can ask to get back the cost of medical expenses from you if you get expenses from the other party.

Glossary

Appeal – A request for your managed care organization to review a denial or a grievance again.
Complaint – A grievance that you communicate to your health insurer or plan.
Copayment – A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.
Durable Medical Equipment (DME) – Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include oxygen equipment, wheelchairs, crutches, or blood testing strips for diabetics.
Emergency Medical Condition – An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid harm.
Emergency Medical Transportation – Ground or air ambulance services for an emergency medical condition.
Emergency Room Care – Emergency services you get in an emergency room.
Emergency Services – Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.
Excluded Services – Health care services that your health insurance or plan doesn't pay for or cover.
Grievance – A complaint to your health insurer or plan.
Habilitation Services and Devices – Health care services such as physical or occupational therapy that help a person keep, learn, or improve skills and functioning for daily living.
Health Insurance – A contract that requires your health insurer to pay your covered health care costs in exchange for a premium.
Home Health Care – Health care services a person receives in a home.
Hospice Services – Services to provide comfort and support for persons in the last stages of a terminal illness and their families.
Hospitalization – Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.
Hospital Outpatient Care – Care in a hospital that usually doesn't require an overnight stay.
Medically Necessary – Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network – The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services.
Non-participating Provider – A provider who doesn't have a contract with your health insurer or plan to provide covered services to you. It may be more difficult to obtain authorization from your health insurer or plan to obtain services from a non-participating provider, instead of a participating provider. In limited cases such as there are no other providers, your health insurer can contract to pay a non-participating provider.
Participating Provider – A Provider who has a contract with your health insurer or plan to provide covered services to you.
Physician Services – Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.
Plan – A benefit, like Medicaid, to pay for your health care services.
Pre-authorization – A decision by your health insurer or plan before you receive it that a healthcare service, treatment plan, prescription drug, or durable medical equipment is medically necessary. This is sometimes called prior authorization, prior approval, or pre-certification. Preauthorization isn't a promise your health insurance or plan will cover the cost.
Premium – The amount that must be paid for your health insurance or plan.
Prescription Drug Coverage – Health insurance or plan that helps pay for prescription drugs and medications.
Prescription Drugs – Drugs and medications that by law require a prescription.
Primary Care Physician – A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.
Primary Care Provider – A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law, who provides, coordinates, or helps a patient access a range of health care services.
Provider – A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified, or accredited as required by state law.
Rehabilitation Services and Devices – Health care services such as physical or occupational therapy that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled.
Skilled Nursing Care – Services from licensed nurses in your own home or in a nursing home.
Specialist – A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.
Urgent Care – Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Parkland
Community Health Plan

September 2026