Parkland Community Health Plan

2026–2027

CHIP Perinate

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_02MH

Parkland Community Health Plan (PCHP)
CHIP Perinate

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

CHIP Perinate Member covers services in the following counties:

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

Member Services:
1-888-814-2352

TTY: For people that are deaf or hearing impaired, please call the Relay of Texas TTY line at **711** and ask them to call the Parkland CHIP/CHIP Perinate Member Services line.

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**
Health and Human Services Commission: CHIP Helpline:	**2-1-1**; pick a language and then press option 2 **1-800-964-2777**

Introduction: Your CHIP Perinate Member Handbook

Welcome to Parkland Community Health Plan (PCHP)
Through Parkland Community Health Plan (PCHP), we are pleased to offer you all the benefits offered in the State of Texas's Children's Health Insurance Program (or "CHIP") Perinatal program and value-added benefits. Information on eligibility and benefits are included in this Member Handbook. You and your perinatal providers will work together to help you have a healthy baby. Our member services can help you find doctors and hospitals in your area, visit our website at www.ParklandHealthPlan.com or contact Member Services at 1-888-814-2352 (TTY 711).

We wrote this member handbook to answer most of your questions about CHIP Perinate. 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 PCHP health plan. If you have any questions about your 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 ID card. We will be more than happy to help you.

At PCHP, if you do not speak English, we are ready to help you in many different languages at any time, day or night. We also have special services for free 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. If you need an audio version, we will get it for you. To get help, just call PCHP Member Services at **1-888-814-2352.**

Tips for members

- Keep this handbook and any additional handbook information for future use.
- Write your ID number in the front of this book or other safe place.
- Always carry your ID card with you.
- Keep your perinatal provider's name and number near the phone.

Plan information and online resources

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:

- Register for our Member Portal
- View health/wellness resources.
- View questions and answers about the CHIP Perinatal program .
- Search our provider directory to help you find perinatal doctors and hospitals in your area.
- Get information on different health topics.

Member safety

We think it is important to teach our members about health safety. Here are some important tips:

- ✓ Be involved in every decision about your healthcare. You can know what you and your doctor can do to improve and/or stay healthy if you are involved.
- ✓ Ask questions. You have a right to question anyone who is involved with your care.
- ✓ Make sure your doctor knows about all medicines you are taking. Medications can include those given to you by your doctor or bought in a store. Ask that these be written down in your medical file.
- ✓ Make sure your doctor knows if you have any allergies or bad reactions to medicines. This can help you avoid getting medicines that could harm you.
- ✓ Ask for information about your healthcare in a language you can understand. Be sure you are clear on the amounts of medicine you should take. You should ask your doctor how you will react if taking one or more kinds of medicines at the same time.

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.
- Member ID Card
- Change your address or phone number.
- Find an in network perinatal providers and hospitals.
- Find out more about how to file a complaint.
- Request a copy of your rights and responsibilities.

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 at 1-888-814-2352, and your call will be returned the next business day. Call your perinatal 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 PCHP 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: PCHP Member Services
PO Box 560307
Dallas, TX 75356

PCHP Member Advocates

PCHP Member Advocates are available to assist members by contacting Member Services at **1-888-814-2352** and requesting to speak to a Member Advocate. They can help members navigate and understand PCHP's benefits and services, including, help with writing complaints and member appeals and to inform members about the following:

- Member rights and responsibilities,
- PCHP's Complaint process,
- PCHP's Appeal process,
- Covered Services available to members, including preventive services, and
- Information about non-capitated Services available to members.

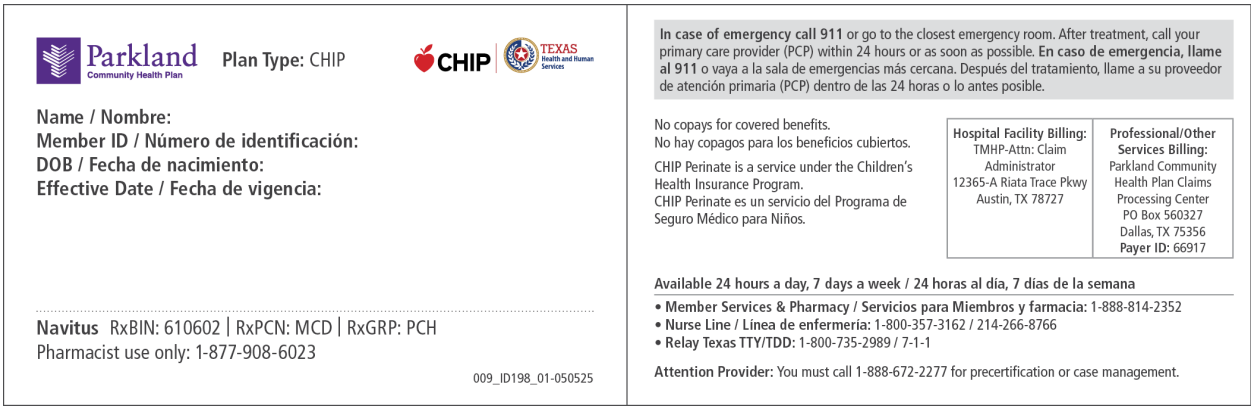
Getting Started

Member Identification (ID) Cards

When you enrolled with us, you will get an ID card from us. You will not get a new ID card every month. Here is what your ID card will look like.

CHIP Perinate ID – Below 198% Federal Poverty Level (FPL)

Front and back of card



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:

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 covered benefits.
No hay copagos para los beneficios cubiertos.

CHIP Perinate is a service under the Children's Health Insurance Program.
CHIP Perinate es un servicio del Programa de Seguro Médico para Niños.

Hospital Facility Billing:
TMHP-Attn: Claim Administrator
12365-A Riata Trace Pkwy
Austin, TX 78727

Professional/Other Services Billing:
Parkland Community Health Plan Claims Processing Center
PO Box 560327
Dallas, TX 75356
Payer ID: 66917

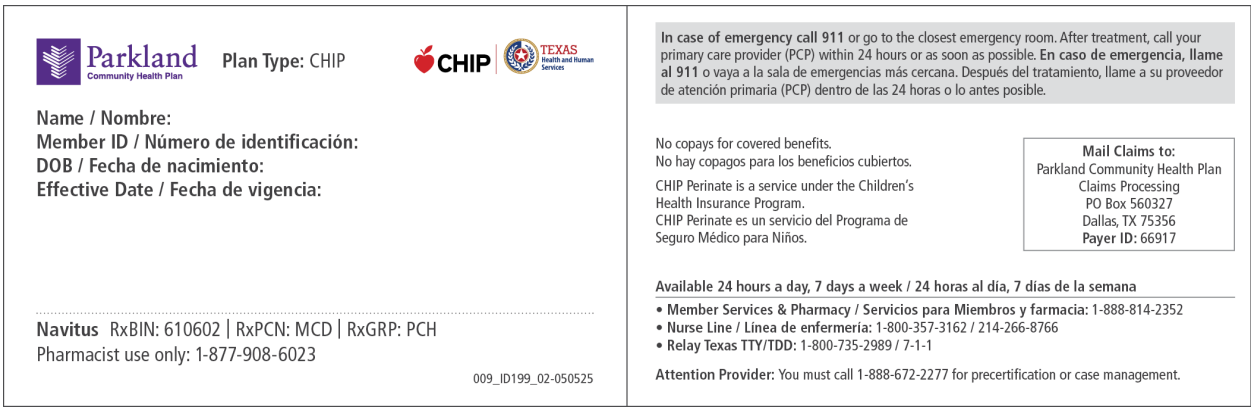
Available 24 hours a day, 7 days a week / 24 horas al día, 7 días de la semana

- **Member Services & Pharmacy / Servicios para Miembros y farmacia:** 1-888-814-2352
- **Nurse Line / Línea de enfermería:** 1-800-357-3162 / 214-266-8766
- **Relay Texas TTY/TDD:** 1-800-735-2989 / 7-1-1

Attention Provider: You must call 1-888-672-2277 for precertification or case management.

CHIP Perinate ID – Above 198% Federal Poverty Level (FPL)

Front and back of card



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:

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 covered benefits.
No hay copagos para los beneficios cubiertos.

CHIP Perinate is a service under the Children's Health Insurance Program.
CHIP Perinate es un servicio del Programa de Seguro Médico para Niños.

Mail Claims to:
Parkland Community Health Plan
Claims Processing
PO Box 560327
Dallas, TX 75356
Payer ID: 66917

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

- **Member Services & Pharmacy / Servicios para Miembros y farmacia:** 1-888-814-2352
- **Nurse Line / Línea de enfermería:** 1-800-357-3162 / 214-266-8766
- **Relay Texas TTY/TDD:** 1-800-735-2989 / 7-1-1

Attention Provider: You must call 1-888-672-2277 for precertification or case management.

How to read your card: The ID card shows you are a PCHP health plan member. Make sure to always carry your ID card with you at all times. Please make sure your information on your 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
- Pharmacy information
- Billing information

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

How to replace your ID card if lost or stolen: Please call our Member Services at 1-888-814-2352 right away so we can send you another ID card. You may also print a new ID card from our website at www.ParklandHealthPlan.com. You will need to register and log in to the member portal.

What do I have to do if I 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 PCHP Member Services at **1-888-814-2352**. Before you get CHIP services in your new area, you must call PCHP Member Services plan, unless you need emergency services. You will continue to get care through PCHP until HHSC changes your address.

Choosing Your Perinatal Provider

How do I choose a perinatal provider?
Please look at our provider directory to get more information on perinatal providers. You must pick a perinatal provider who is in our CHIP Perinate network. You can get a copy of the provider directory on **www.ParklandHealthPlan.com** or by calling us at the toll-free number listed on your ID card.

Will I need a referral?
You do not need a referral for this service.

How soon can I be seen after contacting a perinatal provider for an appointment?
You should be seen by a perinatal provider within 2 weeks of asking for an appointment. If you have problems getting an appointment, please call us toll-free at **1-888-814-2352**.

Can I stay with my perinatal provider if they are not part of PCHP's provider network?
In some cases, yes, you may be able to keep seeing this doctor for care while you pick a new perinatal provider in PCHP's provider network. This could happen if you were getting care from a perinatal provider who is not in our health plan when you joined PCHP.

Please call us at 1-888-814-2352 to find out more about this. PCHP will make a plan with you and your provider, so we all know when you need to start seeing your new PCHP perinatal provider.

Your Out-of-Pocket Costs

How much do I have to pay for my unborn child's health care under CHIP perinatal?
No co-payments or cost sharing is required for covered services listed in the benefits section of this handbook. If you have any questions, please call the Member Services at 1-888-814-2352.

Will I have to pay for services that are not a covered benefit?
If the service is not a covered benefit listed in the benefits section of this handbook, then you will have to pay for the service. If you have any questions, please call the Member Services at 1-888-814-2352.

Provider billing

What if I get a bill from my perinatal provider? Who do I call? What information will they need?
We will only pay for covered services listed previously in this member handbook. If you get a service from your perinatal provider that is not covered, you may have to pay.

If you feel that you should not have gotten the bill or you need help to understand the bill, please call the Member Services at 1-888-814-2352. We will help explain the bill to you. We can talk to the doctor's office for you to explain your benefits. We can also help you arrange for the bill to be paid.

When you call us, please have your ID card and the doctor's bill with you. We will need this information, so we can help you quickly.

Interpreter Services

Can someone interpret when I talk with my 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 **1-888-814-2352**. 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 doctor's office. As soon as you know the date of your appointment, please call Member Services at **1-888-814-2352**. We ask for 72 hours advance notice of a need for an interpreter.

Understanding Your Coverage

CHIP Perinate Plan Information

Provider Information

What is a perinatal provider?
A perinatal provider is the main doctor who provides most of your health care while you are pregnant. Your perinatal provider must be a PCHP health plan provider. The perinatal provider will also send you to other doctors, specialists, or hospitals when special care or services are needed for the health of your unborn child.

What do I need to bring to a perinatal provider's appointment?
You should take the following items with you when you go to your doctor's appointment:

- CHIP Perinate Member ID card.
- A list of all over the counter and prescription medications that you take.
- Your health care records.
- Paper to take notes on information you get from the doctor.

Can a clinic be a perinatal provider? (Rural Health Clinic, federally Qualified Health Center)
If you have been getting health care services at a clinic and you want to keep going there, please pick one of the doctors in the clinic as your perinatal provider. The perinatal provider you pick needs to be listed in our provider directory.

Some of the providers that you can also pick from to be your perinatal provider are OB/GYNs (woman's doctor); Local Public Health Clinics; Federally Qualified Health Clinics (FQHCs); and Rural Health Clinics (RHCs).

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

Changing your health plan

For CHIP Perinate members
Attention: If you meet certain income requirements, your baby will be moved to Medicaid and get 12 months of continuous Medicaid coverage from date of birth.

- Your baby will continue to receive services through the CHIP Program if you meet the CHIP Perinatal requirements. Your baby will get 12 months of continuous CHIP Perinatal coverage through his or her health plan, beginning with the month of enrollment as an unborn child.

What if I want to change health plans?

- Once you pick a health plan for your unborn child, the child must stay in this health plan until the child's CHIP Perinatal coverage ends. The 12-month CHIP Perinatal coverage begins when your unborn child is enrolled in CHIP Perinatal and continues after your child is born.
- If you do ***not*** pick a plan within 15 days of getting the enrollment packet, HHSC will pick a health plan for your unborn child and send you information about that health plan. If HHSC

picks a health plan for your unborn child, you will have 90 days from your effective date of coverage to pick another health plan if you are not happy with the plan HHSC chooses.
- The children must remain with the same health plan until the end of the CHIP Perinatal Member's enrollment period, or the end of the other children's enrollment period, whichever happens last. At that point, you can pick a different health plan for the children.
- You can ask to change health plans:
    - For any reason within 90 days of enrollment in CHIP Perinatal.
    - If you move into a different service delivery area; and
    - For cause at any time.

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 ask to change health plans:
- For any reason within 90 days of enrollment in CHIP Perinatal
- If you move to a different service delivery area
- For cause at any time.

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

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 can be disenrolled from PCHP if:

- You permanently move out of the service area.
- You keep going to the ER when you do not have an emergency.
- You are no longer eligible for CHIP.
- You show a pattern of disruptive or abusive behavior not related to a medical condition.
- You miss many visits without letting your doctor know in advance.
- You let someone else use your ID card.
- You do not follow your doctor's advice.

If there are any changes in your health plan, you will be sent a letter. If you decide to leave PCHP, you should call member services at 1-888-814-2352 or 2-1-1.

Concurrent Enrollment of Family Members in Parkland CHIP Perinatal and Medicaid Coverage for Certain Newborns

If you have children enrolled in the CHIP program, they will remain in the CHIP program but will be moved to PCHP CHIP program. Co-payments, cost-sharing and enrollment fees still apply for those children enrolled in the CHIP program.

An unborn child who is enrolled in CHIP Perinatal will be moved to Medicaid for 12 months of continuous Medicaid coverage, beginning on the date of birth, if the child lives in a family with an income at or below 198% of the federal poverty level (FPL) of the Medicaid eligibility threshold.

An unborn child will continue to receive coverage through the CHIP program as a "CHIP Perinate Newborn" after birth if the child is born to a family with an income above 198% to 200% FPL of the Medicaid eligibility threshold.

Benefits Overview

What is my unborn child's CHIP Perinatal benefits?
Below is a list of some of the medical services you can get from PCHP's CHIP Perinate plan. Some of your benefits do have limits. Call Member Services toll free at **1-888-814-2352** for more benefit information. **Co-pays do not apply to CHIP Perinatal members.**

Costs from labor that does not result in a birth and false labor are not covered.

How do I get these services?
You should see your perinatal 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 ID card.

CHIP Perinate Member (unborn child) covered benefits	Limitations
Inpatient General Acute Services include: Covered medically necessary hospital-provided services: • Operating, recovery and other treatment rooms. • Anesthesia and administration (facility technical component). • Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child and services related to miscarriage or non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). • Inpatient services associated with o miscarriage or	For CHIP Perinates in families with incomes at or below 198% of the Federal Poverty Level, (Perinates who qualify for Medicaid once born), the facility charges are not a covered benefit; however professional services charges associated with labor with delivery are a covered benefit. For CHIP Perinates in families with incomes above 198% up to and including 202% of the Federal Poverty Level, (Perinates who do not qualify for Medicaid once born), benefits are limited to professional service charges and facility charges associated with labor with delivery until birth, and services related to miscarriage or a non-viable pregnancy.

o 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: o Dilation and curettage (d&c) Procedures, o Appropriate provider-administered medications, o Ultrasounds, and o Histological examination of tissue samples	Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child. Hospital-provided services are limited to labor with delivery until birth.
CHIP Perinate Member (unborn child) covered benefits	**Limitations**
Comprehensive Outpatient Hospital, Clinic (including health center) and Ambulatory Health Care Center Services include 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) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Drugs, medications, and biologicals that are medically necessary prescription and injection drugs • 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 includes, but are not limited to: o Dilation and curettage (d&c) procedures, o Appropriate provider-administered medications, o Ultrasounds, and	May require prior authorization and physician prescription. Laboratory and radiological services are limited to services that directly relate to antepartum care and/or the delivery of the covered CHIP Perinate until birth. Ultrasound of the pregnant uterus is a covered benefit of the CHIP Perinatal Program when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational age conformation, or miscarriage or non-viable pregnancy. Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits of the CHIP Perinatal Program with an appropriate diagnosis. Laboratory tests for the CHIP Perinatal Program are limited to: nonstress testing, contraction stress testing, hemoglobin or hematocrit repeated one a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urinalysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody screen for Rh negative women at 28 weeks followed by

○ Histological examination of tissue samples	RHO immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client. Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero) are a covered benefit.
CHIP Perinate Member (unborn child) covered benefits	**Limitations**
Physician/Physician Extender Professional Services Services include, but are not limited to the following: • Medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth. • Physician office visits, in-patient and out-patient services • Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation. • Medically necessary medications, biologicals and materials administered in Physician's office • Professional component (in/outpatient) of surgical services, including: ○ Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery	May require authorization for specialty referral from a primary care provider to an in-network specialist. Requires authorization for all out-of-network specialty referrals. Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age conformation. Professional component of Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentrsis, and FIUT. Professional component associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Professional services associated with miscarriage or non-viable pregnancy include, but are not limited to:

of the covered unborn child until birth. o Administration of anesthesia by physician (other than surgeon) or CRNA o Invasive diagnostic procedures directly related to the labor with delivery of the unborn child. o Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). • Hospital-based physician services (including Physician-performed technical and interpretive components)	• dilation and curettage (D&C) procedures; • appropriate provider administered medications; • ultrasounds, and • histological examination of tissue samples.
CHIP Perinate Member (unborn child) covered benefits	**Limitations**
Prenatal Care and Prepregnancy Family Services and Supplies Services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include: • One (1) visit every four (4) weeks for the first 28 weeks or pregnancy; • (2) one (1) visit every two (2) to three (3) weeks from 28 to 36 weeks of pregnancy; and • (3) one (1) visit per week from 36 weeks to delivery. More frequent visits are allowed as Medically Necessary.	Benefits are limited to: Limit of 20 prenatal visits and two (2) postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained and is subject to retrospective review. Visits after the initial visit must include: • Interim history (problems, marital status, fetal status); • Physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) and • Laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy: repeat antibody screen for Rh negative women at 28 weeks

	followed by rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).
CHIP Perinate Member (unborn child) covered benefits	**Limitations**
Birthing Center Services Covers birthing services provided by a licensed birthing center. Limited to facility services (e.g., labor and delivery)	Applies only to CHIP Perinate members (unborn child) with incomes at 198% FPL to 202% FPL.
CHIP Perinate Member (unborn child) covered benefits	**Limitations**
Services Rendered by a Certified Nurse Midwife or Physician in a Licensed Birthing Center Covers prenatal, birthing, and postpartum services rendered in a licensed birthing center. Prenatal services subject to the following limitations: Services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include: • One (1) visit every four (4) weeks for the first 28 weeks or pregnancy • one (1) visit every two (2) to three (3) weeks from 28 to 36 weeks of pregnancy; and • one (1) visit per week from 36 weeks to delivery More frequent visits are allowed as medically necessary.	Benefits are limited to: • Limit of 20 prenatal visits and two (2) postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained and is subject to retrospective review. • Visits after the initial visit must include: • Interim history (problems, marital status, fetal status); • Physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) and • Laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy: repeat antibody screen for Rh negative women at 28 weeks followed by rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).

CHIP Perinate Member (unborn child) covered benefits	**Limitations**
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services Health plan cannot require authorization as a condition for payment for emergency conditions related to labor and delivery. Covered services are limited to those emergency services that are directly related to the delivery of the covered unborn child until birth. • Emergency services based on prudent layperson definition of emergency health condition. • Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child. • Stabilization services related to the labor and delivery of the covered unborn child. • Emergency ground, air, and water transportation for labor and threatened labor is a covered benefit. • Emergency ground, air, and water transportation for an emergency associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) is a covered benefit.	Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.
CHIP Perinate Member (unborn child) covered benefits	**Limitations**
Case Management Services and Care Coordination Services Case management services are a covered benefit for the unborn child.	These covered services include outreach informing, case management, care coordination, and community referral.
CHIP Perinate Member (unborn child) covered benefits	**Limitations**
Drug Benefits Services include, but are not limited to, the following: Outpatient drugs and biologicals; including pharmacy-dispensed and provider -	Services must be medically necessary for the unborn child.

administered outpatient drugs and biologicals; and Drugs and biologicals provided in an inpatient setting.	
CHIP Perinate Member (unborn child) covered benefits	**Limitations**
Value-Added Services See page **20** for Value-Added Benefits	

What services are not covered?

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

- For CHIP Perinates in families with income at or below the Medicaid eligibility threshold (Perinates who qualify for Medicaid once born), inpatient facility charges are not a covered benefit if associated with the initial Perinatal Newborn admission. "Initial Perinatal Newborn admission" means the hospitalization associated with the birth.
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (i.e. cannot be prescribed for family planning)
- Inpatient and outpatient treatments other than prenatal care, labor with delivery, services related to (a) miscarriage and (b) a non-viable pregnancy, and postpartum care related to the covered unborn child until birth.
- Inpatient mental health services.
- Outpatient mental health services.
- Durable medical equipment or other medically related remedial devices.
- Disposable medical supplies, with the exception of a limited set of disposable medical supplies, when they are obtained from an authorized pharmacy provider.
- Home and community-based health care services.
- Nursing care services.
- Dental services.
- Inpatient substance abuse treatment services and residential substance abuse treatment services.
- Outpatient substance abuse treatment services.
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
- Hospice care.
- Skilled nursing facility and rehabilitation hospital services.
- Emergency services other than those directly related to the labor with delivery of the covered unborn child.
- Transplant services.
- Tobacco Cessation Programs.
- Chiropractic Services.
- Medical transportation not directly related to labor or threatened labor, miscarriage or non-viable pregnancy, and/or delivery of the covered unborn child.
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests

of Member, and other articles which are not required for the specific treatment related to labor with delivery or postpartum care.

- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community.
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court.
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).
- Mechanical organ replacement devices including, but not limited to artificial heart.
- Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor with delivery.
- 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 related to the labor with delivery of the covered unborn child and services provided by an FQHC, as provided in Section 8.1.22 of the Contract.
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity
- 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)
- Corrective orthopedic shoes
- Convenience items
- Over-the-counter medications
- Orthotics primarily used for athletic or recreational purposes.
- Custodial care (care that assists 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 caregiver. This care does not require the continuing attention of trained medical or paramedical personnel.)
- 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, which do not require the skill and training of a nurse.

- Vision training, vision therapy, or vision services
- Reimbursement for school-based physical therapy, or speech therapy services are not covered.
- Donor non-medical expenses
- Charges incurred as a donor of an organ.

What are my unborn child's prescription drug benefits?

CHIP Perinate covers most of the medicine your unborn child needs. If you have questions what drugs are covered for your unborn child, call us at the toll-free number on your ID card.

Extra Benefits

What extra benefits does PCHP offer CHIP Perinate members? (Restrictions and limitations may apply)

Parkland CHIP Perinate 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.
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 Perinate members receive through 2 months postpartum

Category	Value Added Service	Limitations and Restrictions
Extra Help for Pregnant Women	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
	$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
Health and Wellness Services	$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.

How can I get these benefits for my unborn child?
If you have questions or need help with these services, visit the website **www.ParklandHealthPlan.com** or call Member Services at **1-888-814-2352**.

What health education classes does Parkland CHIP Perinate Members 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.

Medically Necessary and Emergency Care

What does medically necessary mean?
Covered services for CHIP Perinate Members must meet the CHIP definition of "Medically Necessary." A CHIP Perinate Member is an unborn child.

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 receive from a perinatal provider or other healthcare provider.

The perinatal provider you choose will help you with all your prenatal medical care. Your perinatal provider will get to know you and do regular check-ups on you and your unborn child. This type of care is known as routine medical care. Your perinatal provider will give you prescriptions for medicines and medical supplies and send you to a specialist if needed during your pregnancy. It is important that you follow your perinatal provider's advice and take part in decisions about your pregnancy.

When you need care, call your perinatal provider. Someone in the doctor's office or clinic will make an appointment for you. It is very important that you keep your appointments. Your perinatal provider should be able to see you within two (2) weeks after you ask for the routine care appointment. Call early to make appointments. If you cannot keep your appointment, call back to let your perinatal 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 have a medical problem that is not an emergency but needs attention the same day.

You must first call your Perinatal provider. If you would like to speak to a nurse, you can call 24-Hour Nurse Line at **1-800-357-3162 or 214-266-8766**. The nurse can help decide if you need to go to the emergency room. Many illnesses do not need to be treated in the ER. A cold, cough, rash, small cuts, minor burns or bruises are not good reasons to go to the ER. If you need urgent care, the perinatal provider should see you within 24 hours after you ask for care.

What is an Emergency and an Emergency Medical Condition?

A CHIP Perinate Member is defined as an unborn child. Emergency care is a covered service if it directly relates to the delivery of the unborn child until birth. Emergency care is provided for the following Emergency Medical Conditions:

- Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child.
- Stabilization services related to the labor with delivery of the covered unborn child.
- Emergency ground, air, and water transportation for labor and threatened labor is a covered benefit;
- Emergency ground, air, and water transportation for an emergency associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) is a covered benefit.

Benefit limits: Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.

What is Emergency Services or Emergency Care?

"Emergency Services" or "Emergency Care" are covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services and that are needed to evaluate or stabilize an Emergency Medical Condition, including post-stabilization care services related to labor and delivery of the unborn child.

How soon can I child expect to be seen?

You should be seen right away if you need 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 need emergency care. Emergency room doctors will handle a true emergency immediately. They will continue treatment until you are out of danger.

- Call **911** or the local emergency hotline or go to the nearest emergency facility. If a delay would not be harmful to your health, call your perinatal provider. Tell your perinatal provider as soon as possible after getting treatment.
- As soon as your health condition is stabilized, the emergency facility should call your perinatal provider for information on your medical history.
- If you are admitted to an inpatient facility, you, a relative, or friend on your behalf should tell your perinatal provider as soon as possible.

After-hours care

How do I get medical care after my Perinatal Provider's office is closed?

If your perinatal provider's office is closed and you get sick at night or on a weekend and cannot wait to get medical care, call your perinatal provider for advice. Your perinatal provider 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 at **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?
If you need medical care when traveling, call us toll-free at **1-888-814-2352** and we will help you find a doctor. If you 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 out of state?
If you are outside of Texas and need medical care when traveling, call us toll-free at **1-888-814-2352** and we will help you find a doctor. If you 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 out of the country?
Medical services performed out of the country are not covered by CHIP.

What is a referral?
A referral is when your perinatal provider sends you to another doctor or service for care for your unborn child that he or she cannot provide. This may be to a specialist or other provider in PCHP's provider network.

What services do not need a referral?
The following services do not require a referral:

- Emergency Care
- Obstetrical/Gynecological care

What if I need services that are not covered by CHIP Perinatal?
You will have to pay for any service you get that is not covered by PCHP or CHIP Perinatal.

You can apply for emergency Medicaid to cover a hospital visit not related to your pregnancy, but you must meet the income limits.

How do I get my medications?
CHIP Perinatal covers most of the medicine your doctor says you need for your pregnancy. Your doctor will write a prescription so you can take it to the drug store or may be able to send the prescription to the drug store for you.

There are no co-payments required for CHIP Perinate 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 drug store not in the network?
Prescriptions filled at other pharmacies that are not in the PCHP pharmacy network will not be covered. All prescriptions must be filled at a network pharmacy.

What do I bring with me to the drug store?
You will need to bring the prescription your doctor wrote for you. You will also need to show your PCHP ID card.

What if I need my medications delivered to me?
Please visit the on-line pharmacy listing OR call Member Services at **1-888-814-2352** for drug stores that offer delivery.

Who do I call if I have problems getting my medications?
If you have a problem getting your medications, call Member Services at **1-888-814-2352**.

What if I can't get the medication my doctor ordered approved?
If your doctor cannot be reached to approve a prescription, you may be able to get a three-day emergency supply of your medication.

Call Member Services at **1-888-814-2352** for help with your medications and refills.

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

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 Services Advocate 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 cannot 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 Advocate can help you file a complaint. The Member Service Advocate will write down your concern. Please call Member Services at 1-888-814-2352.

How long will it take to process my complaint?
Your complaint will be handled within thirty (30) calendar days from the date PCHP receives your complaint. It could take less than 30 days. You will get a letter that tells you how your complaint was resolved. This letter will explain the complete complaint and appeal process. It will also tell you about your appeal rights.

What are the requirements and timeframes for filing a complaint?
There is not a time limit for submission of a complaint. When we get the complaint from you, we will send you a letter within five (5) days to let you know that your complaint came to us. We will send you another letter within thirty (30) days from the date we got your complaint that will give you the results.

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, MC: CO-CP
PO Box 12030
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

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 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.

Submitting an Appeal

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

If we deny or limit your doctor's request for a covered service for you, 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 can send us more information to show why you do not agree with the decision. You can call us at 1-888-814-2352 and ask for an appeal. The Member Service Advocate 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 services are denied, you 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 are in the hospital or are 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, the Member Service Advocate 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 us at the toll-free number at 1-888-814-2352 and ask for the Member Advocate. 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 1-888-814-2352 or writing to:

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

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

Expedited Appeal Process

What is an expedited appeal?
An 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 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: Member Service Advocate
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 1-888-814-2352.

What are the timeframes for an 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 expedited appeal?
You can ask for an appeal by calling us at **1-888-814-2352** and asking for the Member Service Advocate or writing to:

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

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

What happens if PCHP denies the request for an 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:

Mail: MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534
Fax : 1-888-866-6190
Online Portal: externalappeal.com.gov

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 believe 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 – CHIP Perinatal

MEMBER RIGHTS

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your unborn child's health plan, doctors, hospitals, and other providers.
2. You have a right to know how the perinatal providers are paid. Some may get a fixed payment no matter how often you visit. Others get paid based on the services they provide for your unborn child. You have a right to know about what those payments are and how they work.
3. You have a right to know how the health plan decides whether a perinatal service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
4. You have a right to know the names of the hospitals and other Perinatal providers in the health plan and their addresses.
5. You have a right to pick from a list of healthcare providers that is large enough so that your unborn child can get the right kind of care when it is needed.
6. You have a right to emergency perinatal services if you reasonably believe your unborn child's life is in danger, or that your unborn child would be seriously hurt without getting treated right away. Coverage of such emergencies is available without first checking with the health plan.
7. You have the right and responsibility to take part in all the choices about your unborn child's healthcare.
8. You have the right to speak for your unborn child in all treatment choices.
9. You have the right to be treated fairly by the health plan, doctors, hospitals, and other providers.
10. You have the right to talk to your perinatal provider in private and to have your medical records kept private. You have the right to look over and copy your medical records and to ask for changes to those records.
11. You have the right to a fair and quick process for solving problems with the health plan and the plan's doctors, hospitals and others who provide perinatal services for your unborn child. If the health plan says it will not pay for a covered perinatal service or benefit that your unborn 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.
12. You have a right to know that doctors, hospitals, and other Perinatal providers can give you information about your or your unborn child's health status, medical care, or treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

MEMBER RESPONSIBILITIES

You and your health plan both have an interest in having your baby born healthy. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Stay away from tobacco and eat a healthy diet.
2. You must become involved in the decisions about your unborn child's care.
3. If you have a disagreement with the health plan, you must try first to resolve it using the health plan's complaint process.

4. You must learn about what your health plan does and does not cover. Read your CHIP Perinatal Program Handbook to understand how the rules work.
5. 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.
6. You must report misuse of CHIP Perinatal services by health care providers, other members, or health plans.
7. 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 (HHS) 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.

When does CHIP perinatal coverage end?
CHIP perinatal coverage ends the last day of the baby's birth month. You should still go to your two postpartum visits after you have your baby. Your child can keep getting his or her health care benefits from us through Medicaid or CHIP.

If your income is at or below the Medicaid eligibility threshold, then your baby is eligible for 12 months of Medicaid health care benefits starting on the date of birth.

If your income is above the Medicaid eligibility threshold, your baby can get CHIP benefits through the CHIP program for as long as heor she qualifies.

Will the state send me anything when my CHIP Perinatal coverage ends?
Yes, HHSC will send you a letter stating when your coverage ends. They will also send you information telling you what programs your child may be eligible to receive. Please be sure to complete and mail back any forms you receive in the mail.

How does renewal work?
There is not renewal process for CHIP Perinatal. Your child can keep getting healthcare benefits from us if he or she still qualifies for CHIP or Medicaid.

Can I choose my baby's primary care provider before he/she is born? Who do I call? What information do they need?
Yes, you can select a primary care provider before your child is born. If you already know what primary care provider you would like for your child, you can call our Member Services Department at **1-888-814-2352** and a representative will be able to help you.

He/she will need the mother's name, baby's name, date of birth and baby's CHIP ID number, if available. If you do *not* know what primary care provider you would like for your child, you can request a PCHP CHIP provider directory at no cost.

Remember: the primary care provider will be the one you call when your child needs care. Your child's CHIP primary care provider is also part of a "network." When you choose this primary care provider, you also choose this primary care provider's network.

This means that you should not take your child to any other provider who is not in the primary care provider's network, even if this provider is listed with PCHP CHIP Provider Network.

You can also see or print a copy of the provider directory at **www.ParklandHealthPlan.com**.

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.
If you 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 Service Coordinator 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 at 1-888-814-2352 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 do not discriminate against people and that means we will not 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:

- CHIP Perinate: 1-888-814-2352

Do you feel you did not 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 **PCHPComplainsandAppeals@phhs.org**

If you need help filing? Call our Member Services and request a Member Advocate.

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

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

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