2024-2025 STAR Member Handbook

For more Parkland Community Health Plan (PCHP) information, call **1-888-672-2277**.

PCHP is part of the State of Texas Access Reform (STAR) program covering Medicaid members in Dallas, Collin, Ellis, Hunt, Kaufman, Navarro and Rockwall counties.

Dallas Service Area

www.ParklandHealthPlan.com

093_071124_MS

September 2024

Parkland Community Health Plan (PCHP)
STAR (Medicaid) Member Handbook

PCHP covers STAR members in the Dallas service area in the following counties:
Dallas, Collin, Ellis, Hunt, Kaufman, Navarro and Rockwall counties.

Member Services
1-888-672-2277

www.ParklandHealthPlan.com

Personal Information

My STAR (Medicaid) member ID number: ______________________________

My Primary Care Provider (PCP) is:______________________________

My Primary Care Provider's address is: ______________________________

My Primary Care Provider's telephone number is: ______________________________

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

Parkland Community Health Plan

STAR (Medicaid) Member Handbook

2024-2025

Dallas service area

Serving: Dallas, Collin, Ellis, Hunt, Kaufman, Navarro, and Rockwall counties

Member Services
1-888-672-2277 (toll free)

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

www.ParklandHealthPlan.com

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Your STAR (Medicaid) Member Handbook

Welcome to Parkland Community Health Plan (PCHP)! PCHP is a plan that makes it easier for you to get good medical care. With STAR, you will get all the Medicaid benefits – and more. You will also be able to pick a doctor or healthcare provider from a list of doctors and healthcare providers close to where you live. The doctor or healthcare provider you pick will be your PCHP Primary Care Provider and will help you take care of all your healthcare needs.

We wrote this Member Handbook to answer most of your questions about your STAR benefits. 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.

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, or 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 **1-888-672-2277.**

Tips for our members

- Always carry your PCHP ID card and Your Texas Benefits Medicaid card.
- Your primary care provider's name will appear on your PCHP ID Card. Check your ID card to make sure the information is correct.
- Make an appointment with your primary care provider soon to get to know your doctor.
- When you call your primary care provider for appointments, tell them you are a Parkland Community Health Plan STAR member.
- Call your primary care provider when you need care.
- Follow your primary care provider's advice.
- Use the hospital Emergency Room (ER) **only** for emergencies.

Plan information and resources online

As a member of PCHP, you can ask for and receive the following information at any time. To make this easy for you, we have some of this information available 24 hours a day, 7 days a week.

- **Parkland Community Health Plan website: www.ParklandHealthPlan.com**
  Get information 24 hours a day, 7 days a week on our website. You can find information and answers to your questions without waiting to call us. This website allows you to:
    - ✓ See our Member Handbook
    - ✓ See Member rights and responsibilities
    - ✓ See questions and answers about Medicaid
    - ✓ Get information on different health topics
    - ✓ Search our provider directory to find in-network doctors, hospitals, and pharmacies in your area.
- **Provider directory resource:** Our provider directory has a list of all in-network provider types along with information like their names, addresses, and phone numbers. You can also find information such as their specialty, board certification, languages spoken, and

much more. The latest directory can always be found at **www.ParklandHealthPlan.com**. Call Member Services if you need help locating a doctor or if you would like us to send you a printed copy.

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 amount 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.

Parkland Community Health Plan 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 **1-888-672-2277**. 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 and weekends, you can contact our Nurse Line 1-888-667-7890, or you can 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. Interpreter services 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 **1-888-672-2277,** or you can write us at

Parkland Community Health Plan
Attention: PCHP Member Services
P.O. Box 560307
Dallas, TX 75356

Behavioral Health Department

Support for Behavioral health needs(including mental health and substance use) are available 24 hours a day, 7 days a week through Carelon Behavioral Health at **1-800-945-4644**. Staff members are available who speak both English and Spanish. Interpreter services are available upon request.

If you or 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 **1-888-672-2277** to let us know. You should also call your doctor to schedule a follow-up visit as soon as possible.

Nonemergency Medical Transportation (NEMT) – Access2Care

Parkland Community Health Plan offers nonemergency medical transportation (NEMT) to all STAR members. Members must use Access2Care to set up nonemergency medical transportation.

You can contact Access2Care at least two workdays before your appointment to schedule a trip.

Access2Care – Member Services
1-833-931-3844
Mon-Fri, 8am-5pm (CT)

Access2Care – Where's My Ride
1-833-931-3844
Mon-Sat, 5am-7pm (CT)

Information is available in English and Spanish. Interpreter services available upon request.

If you 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 Access2Care Member Services line.

PCHP Member Advocates

PCHP Member Advocates are available to assist members by contacting Member Services at **1-888-672-2277** and requesting to speak to a Member Advocate. They can help members navigate and understand PCHP's benefits and services, including, writing complaints and to inform members about the following:

- Members 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.

Other Important Numbers

Parkland 24-Hour Nurse Line 24 hours a day, 7 days a week	Toll Free: **1-888-667-7890** or Direct Line: **214-266-8773**
Vision Services: Avesis Vision	**1-866-678-7113**
Ombudsman Managed Care Assistance Team	**1-866-566-8989** TTY: **1-866-222-4306**
STAR Help Line	**1-800-964-2777**
Dental Services: ✓ DentaQuest ✓ MCNA Dental Plans ✓ UnitedHealthcare Dental	 **1-800-516-0165** **1-855-691-6262** **1-800-822-5353**

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 became effective 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.

Healthcare 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 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 permission

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 it, you can write to us. We cannot use or share your genetic information when we make the decision to provide you healthcare 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, you can 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 in touch with you.
  - If you think the way we keep in touch with you is not private enough, call us.
  - We will do our best to be in touch with 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 permission.
- We will tell you if we do this in a letter.

Call us toll-free at **1-888-672-2277** 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 560347
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 are unhappy 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 secure and is kept in safe areas. We protect entry to our computers and buildings. This helps us to control 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 of 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:
PCHP Medicaid STAR: 1-888-672-2277

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, **1-888-672-2277** (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)

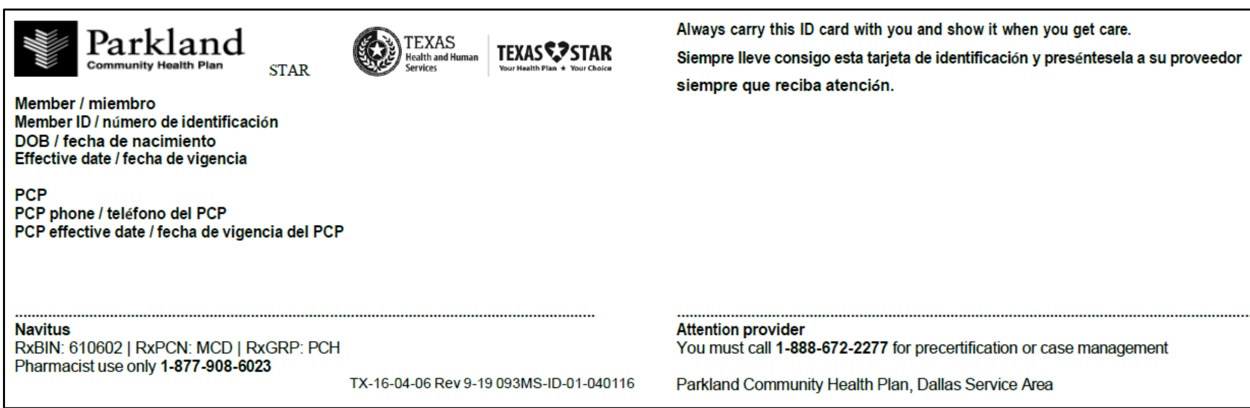
For a complaint form, visit https://www.hhs.gov/ocr/complaints/index.html

Member Identification (ID) Cards

When you sign up with PCHP, you will get an ID card from us. You will not get a new ID card every month. If you call us to change your primary care provider, you will get a new card.

How to read your card: The ID card lists the name and phone number(s) of your primary care provider. The back of the ID card has important phone numbers for you to call if you need help. 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
- 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



Parkland Community Health Plan
STAR
TEXAS Health and Human Services
TEXAS STAR Your Health Plan ★ Your Choice

Member / miembro
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

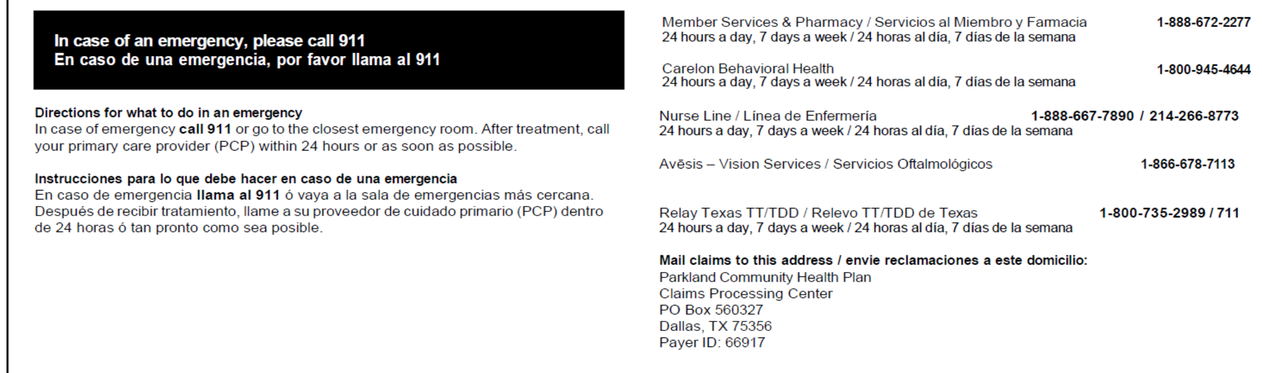
Navitus
RxBIN: 610602 | RxPCN: MCD | RxGRP: PCH
Pharmacist use only **1-877-908-6023**

TX-16-04-06 Rev 9-19 093MS-ID-01-040116

Always carry this ID card with you and show it when you get care.
Siempre lleve consigo esta tarjeta de identificación y preséntesela a su proveedor siempre que reciba atención.

Attention provider
You must call **1-888-672-2277** for precertification or case management

Parkland Community Health Plan, Dallas Service Area



In case of an emergency, please call 911
En caso de una emergencia, por favor llama al 911

Directions for what to do in an emergency
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.

Instrucciones para lo que debe hacer en caso de una emergencia
En caso de emergencia **llama al 911** ó vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame a su proveedor de cuidado primario (PCP) dentro de 24 horas ó tan pronto como sea posible.

Member Services & Pharmacy / Servicios al Miembro y Farmacia **1-888-672-2277**
24 hours a day, 7 days a week / 24 horas al día, 7 días de la semana

Carelon Behavioral Health **1-800-945-4644**
24 hours a day, 7 days a week / 24 horas al día, 7 días de la semana

Nurse Line / Línea de Enfermería **1-888-667-7890 / 214-266-8773**
24 hours a day, 7 days a week / 24 horas al día, 7 días de la semana

Avēsis – Vision Services / Servicios Oftalmológicos **1-866-678-7113**

Relay Texas TT/TDD / Relevo TT/TDD de Texas **1-800-735-2989 / 711**
24 hours a day, 7 days a week / 24 horas al día, 7 días de la semana

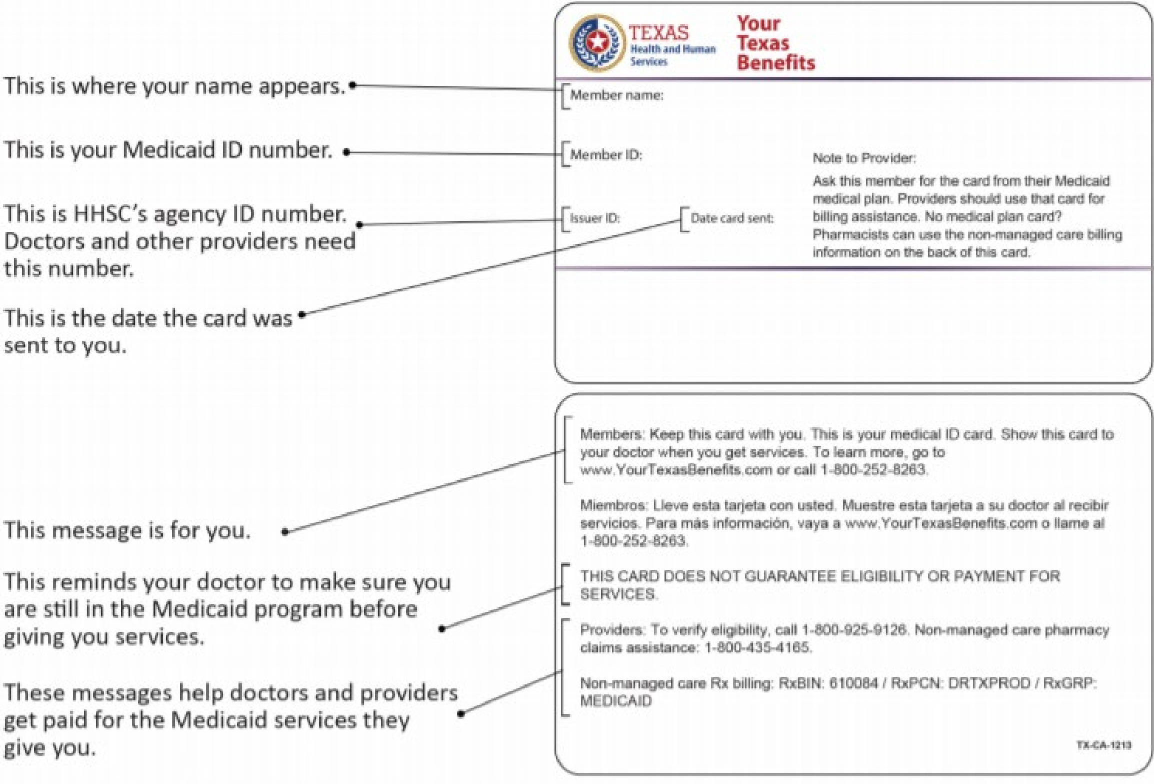
Mail claims to this address / envie reclamaciones a este domicilio:
Parkland Community Health Plan
Claims Processing Center
PO Box 560327
Dallas, TX 75356
Payer ID: 66917

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 card if lost or stolen: Call us right away at 1-888-672-2277, so we can send you another ID card.

Your Texas Benefits Medicaid Card

When you are approved for Medicaid, you will get a Your Texas Benefits Medicaid Card. This plastic card will be your everyday Medicaid card. You should carry and protect it just like your driver's license or a credit card. Your doctor can use the card to find out if you have Medicaid benefits when you go for a visit.



You will be issued only one card and will receive a new card only if your card is lost or stolen. If your Medicaid card is lost or stolen, you can get a new one by calling toll-free **1-800-252-8263** or by going online to order or print a temporary card at www.YourTexasBenefits.com**.**

If you are not sure if you are covered by Medicaid, you can find out by calling toll-free at **1-800-252-8263**. You can also call **2-1-1**. First pick a language and then pick option 2.

Your health information is a list of medical services and drugs that you have gotten through Medicaid. We share it with Medicaid doctors to help them decide what healthcare you need. If you don't want your doctors to see your medical and dental information through the secure

online network, call toll-free at **1-800-252-8263** or opt out of sharing your health information at www.YourTexasBenefits.com.

Your Texas Benefits Medicaid card has these facts printed on the front:

- Your name and Medicaid ID number.
- The date the card was sent to you.
- The name of the Medicaid program you're in if you get:
  - Medicare (QMB, MQMB)
  - Healthy Texas Women Program (HTW)
  - Hospice
  - STAR Health
  - Emergency Medicaid, or
  - Presumptive Eligibility for Pregnant Women (PE).
- Facts your drugstore will need to bill Medicaid.
- The name of your doctor and drugstore if you're in the Medicaid Lock-in program.

The back of the Your Texas Benefits Medicaid card has a website you can visit (**www.YourTexasBenefits.com)** and a phone number you can call toll-free (**1-800-252-8263)** if you have questions about the new card.
If you forget your card, your doctor, dentist, or drugstore can use the phone or the internet to make sure you get Medicaid benefits.

The YourTexasBenefits.com Medicaid Client Portal

You can use the Medicaid Client Portal to do all of the following for yourself or anyone whose medical or dental information you are allowed to access:

- View, print, and order a YTB Medicaid card
- See your medical and dental plans
- See your benefit information
- See STAR and STAR Kids Texas Health Steps alerts
- See broadcast alerts
- See diagnoses and treatments
- See vaccines
- See prescription medicines
- Choose whether to let Medicaid doctors and staff see your available medical and dental information

To access the portal, go to www.YourTexasBenefits.com.

- Click Log In.
- Enter your User Name and Password. If you don't have an account, click Create a new account.
- Click Manage.
- Go to the "Quick links" section.

- Click Medicaid & CHIP Services.
- Click View services and available health information.

Note: The YourTexasBenefits.com Medicaid Client Portal displays information for active clients only. A Legally Authorized Representative may view the information of anyone who is a part of their case.

Information about the temporary ID card (Form 1027-A)
Medicaid also has a temporary ID card called a Form 1027-A. You will get this card in the mail when Your Texas Benefits Medicaid Card has been lost or stolen. The Medicaid temporary ID card tells providers about you and the services that you can get for the time period listed on the Form 1027-A.

Be sure to read the back of the Form 1027-A. The back of the card tells you how and when to use the card. There is a box that has specific information for providers.

You must take your Form 1027-A and your Health Plan ID card with you when you get any healthcare services. You will need to show these cards every time you need services. You can use the temporary ID card until you get Your Texas Benefits Medicaid Card.

Primary Care Providers

What is a primary care provider?
A primary care provider is your main doctor, nurse, or clinic that gives you most of your healthcare. This is called your "medical home". It will help with all the medical care you need. Your primary care provider can take care of routine medical problems. Sometimes you may 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 need to be admitted to a hospital, your primary care provider can arrange that for you.

Our goal is your good health. We urge you to see your 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 so he or she can help you plan for your future healthcare needs. Getting started with your doctor can also help prevent delays in care when you are sick. Remember that you and your primary care provider are the most important members of your healthcare team.

Can a specialist ever be considered a PCP?
You can keep seeing your current primary care provider if the primary care provider is listed in our provider directory. There might be times when we can let a specialist be your primary care provider. The provider directory is a good source to locate these specialists. Also, you can call Member Services to help you.

Can a clinic be my primary care provider? (Rural Health Clinic/Federally Qualified Health Center)

If you receive healthcare services at a clinic and you want to keep going there, please pick one of the doctors in the clinic as your primary care provider. The primary care provider you pick needs to be listed in our provider directory.

Some of the providers that you can also pick from to be your primary care provider 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 who is in our Parkland Community Health Plan network. You can get a copy of the provider directory at **www.ParklandHealthPlan.com** or by calling us at **1-888-672-2277**.

Visiting your primary care provider

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

- Your Texas Benefits Medicaid Card and/or your Form 1027-A
- PCHP ID card
- Immunization (shot) records
- 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. The Texas Health Steps/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 20 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 Texas Health Steps/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.

What type of care does not require me to first be seen by my primary care provider?

For the following types of care, you do not have to go to your primary care provider first:

- Emergency
- OB/GYN
- Family planning
- Routine eye care
- Behavioral health
- Texas Health Steps medical and dental check-ups

To learn more, use our website, **www.ParklandHealthPlan.com,** or call us at the number on your ID card.

Changing your Primary Care Provider

How can I change my primary care provider?
You can change your primary care provider by calling us at the toll-free number on your 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 providers by calling us toll-free at **1-888-672-2277** or writing to: Parkland Community Health Plan Attn: Member Services, P.O. Box 560307, Dallas, Texas 75356.

When will my primary care provider change become effective?
If you change your primary care provider, you will get a new ID card. The new ID card will tell you the new primary care provider's name, address, phone number, and date the new primary care provider will be effective. The primary care provider change will become effective the same day that you call Member Services to make the change.

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

- The primary care provider you picked is not accepting new patients, or
- The primary care provider you picked is no longer a part of Parkland Community Health Plan.

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

- You often miss your appointments and do not call to let the primary care provider know.
- You do not follow advice from your primary care provider.

What if I choose to go to another doctor who is not my primary care provider?

You will need to go to your primary care provider for most health services or you may have to pay out of pocket.

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

After-Hours Care

How do I get medical care after my primary care provider's office is closed?
If you get sick at night or on a weekend and cannot wait to get medical care, call your primary care provider. Your primary care provider or another doctor is ready to help by phone 24 hours a day, 7 days a week. You may also call the Parkland 24-Hour Nurse Line at **1-888-667-7890** or **214-266-8773** to speak with a registered nurse to help you decide what to do.

Medicaid Lock-In Program

What is the Medicaid Lock-in Program?
You may be put in the Lock-In Program if you do not follow Medicaid rules. It checks how you use Medicaid pharmacy services. Your Medicaid benefits remain the same. Changing to a different MCO will not change the Lock-In status.

To avoid being put in the Medicaid Lock-in Program:

- Pick one drugstore at one location to use all the time.
- Be sure your main doctor, main dentist, or the specialists they refer you to are the only doctors that give you prescriptions.
- Do not get the same type of medicine from different doctors.

To learn more, call Member Services at 1-888-672-2277.

Physician Incentive Plan Information

The MCO 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, PCHP does not have a physician incentive plan.

Changing Health Plans

What if I want to change health plans? Who do I call?

You can change your health plan by calling the Texas STAR Program Helpline at **1-800-964-2777**.

How many times can I change health plans?
You can change health plans as often as you want.

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.

Disenrollment from Parkland Community Health Plan

Can PCHP ask that I get dropped from their health plan (for non-compliance, etc.)?
PCHP can ask that you be dropped from our plan for "good cause." Some examples of "good cause" are:

- You frequently do not follow your doctor's advice.
- You move out of the service area.
- You keep going to the Emergency Room (ER) when you do not have an emergency.
- You keep going to another doctor or clinic without first getting approval from your primary care provider.
- You or your children show a pattern of disruptive or abusive behavior not related to a medical condition.
- You miss many appointments without letting your doctor know in advance.
- You let someone else use your ID card.
- Fraud or abuse.

PCHP will not ask you to leave the health plan before talking with you first. We want to work with you to get the best healthcare possible. Call Member Services at
1-888-672-2277 if you have questions.

Benefits

What are my health care benefits?
You should see your primary care provider to ask about medical services. Please follow your primary care provider's advice. Your primary care provider is responsible for coordinating all your care. Here is a list of services you can get:

- Preventive services. This includes an annual adult well check for patients 21 years of age and older
- Ambulance services
- Audiology services. This includes hearing aids for adults (audiology services and hearing aids for children 20 years old and younger are a non-capitated service and provided through the Hearing Services for Children Program.)
- Behavioral Health Services, including:
  - ➢ Acute inpatient mental health services
  - ➢ Mental Health Rehabilitative Services
  - ➢ Inpatient mental health services
  - ➢ Outpatient mental health services
  - ➢ Psychiatry services
- Outpatient substance abuse use disorder treatment services including:
  - ➢ Assessment
  - ➢ Detoxification services
  - ➢ Counseling Treatment
  - ➢ Medication assisted therapy
- Residential substance use disorder treatment services including:
  - ➢ Detoxification services
  - ➢ Substance use disorder treatment (including room and board)
- Birthing services provided by a physician or Advanced Practice Nurse in a licensed birthing center
- Birthing services provided by a certified nurse midwife in a birthing center
- Cancer screening, diagnostic and treatment services
- Chiropractic services
- Dialysis
- Durable medical equipment and supplies
- Emergency services
- Family planning services
- Home health care services
- Hospital services, including inpatient and outpatient
- Laboratory
- Mastectomy, breast reconstruction, and related follow-up procedures, including:
  - ➢ Inpatient services; outpatient services provided at an outpatient hospital and ambulatory health care center as clinically appropriate; and physician and professional services provided in an office, inpatient, or outpatient setting for:
    - ✓ All stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed;
    - ✓ Surgery and reconstruction on the other breast to produce symmetrical appearance;
    - ✓ Treatment of physical complications from the mastectomy and treatment of lymphedemas; and
    - ✓ Prophylactic mastectomy to prevent the development of breast cancer.

- ✓ External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed.
- Medical checkups and Comprehensive Care Program (CCP) services for children 20 years old and younger through the Texas Health Steps Program
- Oral evaluation and fluoride varnish in the medical home in conjunction with Texas Health Steps medical checkup for children 6 months through 35 months of age.
- Podiatry
- Prenatal care
- Primary care services
- Preventive services including an annual adult well check for patients 21 years of age and over
- Radiology, imaging, and X-rays
- Specialty physician services
- Therapies-physical, occupational, and speech
- Transplantation of organs and tissues
- Vision (Includes optometry and glasses. Contact lenses are only covered if they are medically
  necessary for vision correction, which cannot be accomplished by glasses.)

Services covered for member's birth through 20 years of age can be different than services covered for members 21 years of age or older.

How do I get these services?
You should see your doctor to ask about medical services. To learn how to get these or other services, please use the website, **www. ParklandHealthPlan.com,** or call us at **1-888-672-2277**.

Are there any limits to any covered services?
There can be limits on some services. Call us at the number on your ID card to learn more.

What services are not covered?
PCHP does not cover all health care services. The following are health services that are not covered by STAR Medicaid. These services include but are not limited to:

- Any services or supplies that are not medically necessary.
- Supplies in connection with cosmetic surgery except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member, or when prior authorized for specific purposes by TMHP (including the removal of keloid scars).
- Autopsies
- Biofeedback therapy
- Cosmetic surgery (such as a face-lift)
- Experimental medicines or procedures
- Healing using needles and pins (Acupuncture)
- Hospital bereavement
- Hypnosis

- Infertility treatment
- Sex change operations
- Intragastric balloon for obesity
- In-vitro fertilization
- Mastectomy for diagnosis of fibrocystic disease in the absence of documented risk factors
- Reversal of sterilization
- Non-authorized services.

If you agree to get services that we do not cover or approve, you might have to pay for them.

What are my prescription drug benefits?
PCHP covers all prescription drugs approved by the Texas Medicaid program. For a listing of covered drugs, please go to our website, www. ParklandHealthPlan.com, or call us at the number on your ID card.

Additional Benefits

What extra benefits do I get as a member of PCHP?
PCHP members get the following value-added services and extra benefits:

Nurse Line

24-Hour Nurse Line: You can talk to a nurse 24 hours a day, 7 days a week. The nurse can help you with questions or help you decide what to do about your health needs. Call your doctor first with any questions or concerns about your healthcare needs. Please call toll-free **1-888-667-7890** or **214-266-8773**.

Extra Help with Getting a Ride

- Free ride to and from a grocery store, food bank, WIC office, or STAR renewal appointment once per month.

Disease Management

- Free membership in Parkland Community Health Plan's *Be in Control* program with educational materials and resources to support the management of asthma and diabetes.
- $20 value to be used on either a gift card or items from a rewards catalog (categories include movement & fitness, athletics, children's activities, outdoors, baby, personal care, essentials, kitchen & nutrition, and education & creativity) annually for completion of diabetic (retinal or dilated) eye exam for members 15 years and older.
- $20 value to be used on either a gift card or items from a rewards catalog for completing: HB/A1c blood test once every 6 months for ages 18 and older.

Dental Services

- $400 allowance per year for dental services (available for ages 21 and older), including:
  - Checkups.
  - X-rays.
  - Cleanings.

Extra Vision Services

- $100 allowance for members every 2 years toward upgrades on frames.

Discount Pharmacy / Over-the-Counter Benefits

- $20 value to be used on either a gift card for over-the- counter medicines or other items from a rewards catalog (categories include movement & fitness, athletics, children's activities, outdoors, baby, personal care, essentials, kitchen & nutrition, and education & creativity) when you complete your first Parkland Community Health Plan's Health Risk Assessment (HRA).

Sports and School Physicals

- One free sports physical per school year for each covered member ages 5 – 19.

Temporary Phone Help

- Free Android™ smartphone with unlimited monthly data, phone call minutes, and text messaging plus free 4.5 GB of mobile hotspot data for members enrolled in the Federal Lifeline Program. Unlimited calls and text to:
  - Parkland Community Health Plan Member Services.
  - Health education text messages, including Text4Babies, Text4Kids, Text4Health, Care4Life, and Text2Quit.

Help for Members with Asthma

- $60 value to be used on either a gift card or items from a rewards catalog (including hypoallergenic bedding) for members who refill asthma medication prescription (every 60 days for 2 refills worth $10).
- $50 value to be used on either a gift card or items from a rewards catalog (including hypoallergenic bedding) if you are asthmatic and remain enrolled for 6 months annually in Parkland Community Health Plan’s free Be In Control Program.
- $20 value to be used on either a gift card or items from a reward catalog (hypoallergenic bedding) when you remain enrolled for 3 months in the Be in Control program.

Extra Help for Pregnant Women

- Free meal service for pregnant women starting at the 2nd trimester through 120 days post-partum, CHIP Perinate through 60 days postpartum.
- You can request one free family-style meal (feeds 4) per month.

- Free car seat once you complete your first prenatal visit within the 1st trimester or within 42 days of your enrollment with Parkland Community Health Plan.
- Free portable play yard with bassinet, one per pregnancy, when you receive your postpartum checkup within 7-84 days of delivery, while enrolled with Parkland Community Health Plan.
- $25 value to use on either a gift card from Valero gas station or kitchen items from a reward catalog, for pregnant members who complete more than 5 prenatal visits.

Health and Wellness Services

- $20 value to be used on either a gift card or items from a rewards catalog (categories include movement & fitness, athletics, children's activities, outdoors, baby, personal care, essentials, kitchen & nutrition, and education & creativity) for new members who complete a PCP visit within 90 days of joining Parkland Community Health Plan.
- $30 value to be used on either a gift card or items from a rewards catalog (categories include movement & fitness, athletics, children's activities, outdoors, baby, personal care, essentials, kitchen & nutrition, and education & creativity) each year when you complete a follow-up visit with your primary care provider within 7 days of a hospital discharge.
- $30 value to be used on either a gift card or items from a rewards catalog (categories include movement & fitness, athletics, children's activities, outdoors, baby, personal care, essentials, kitchen & nutrition, and education & creativity) for getting your annual flu shot, between the months of September through November.
- $20 value to be used on either a gift card or items from a rewards catalog (categories include movement & fitness, athletics, children's activities, outdoors, baby, personal care, essentials, kitchen & nutrition, and education & creativity) for getting your annual flu shot, between the months of December through August.

Healthy Play and Exercise Programs

- $30 value to be used on either a gift card or items from a rewards catalog (categories include movement & fitness, athletics, children's activities, outdoors, baby, personal care, essentials, kitchen & nutrition, and education & creativity) each year for everyone ages 10 and older who completes the free 3-week Step-Up challenge.

Gift Programs

- Up to $160 value to be used on either gift cards or items from a rewards catalog (categories include movement & fitness, athletics, children's activities, outdoors, baby, personal care, essentials, kitchen & nutrition, and education & creativity) for the completion of up to 6 timely Texas Health Steps checkups between ages 0-15 months and up to 2 timely well-child checkups between ages 16-30 months.
- $20 value to be used on either a gift card or items from a rewards catalog (categories include movement & fitness, athletics, children's activities, outdoors, baby, personal care, essentials, kitchen & nutrition, and education & creativity) when you complete a timely Well Adolescent Texas Health Steps checkup for ages 12-18.

- $20 value to be used on either a gift card or items from a rewards catalog (categories include movement & fitness, athletics, children's activities, outdoors, baby, personal care, essentials, kitchen & nutrition, and education & creativity) for first-time member enrollment into the online Member Portal at www.parklandhealthplan.com, once per lifetime.
- $20 reward value to be used on either a gift card or items from a rewards catalog (categories include movement & fitness, athletics, children's activities, outdoors, baby, personal care, essentials, kitchen & nutrition, and education & creativity) each year when you receive initial medication for ADHD and receive a follow-up visit within 30 days of initiation.

Inpatient Follow-Up Incentive Program

- $30 value to be used on either a gift card or items from a rewards catalog (categories include movement & fitness, athletics, children's activities, outdoors, baby, personal care, essentials, kitchen & nutrition, and education & creativity) each year when you complete a behavioral health follow-up within 7 days after hospitalization for a behavioral health diagnosis.
- $20 value to be used on either a gift card or items from a rewards catalog (categories include movement & fitness, athletics, children's activities, outdoors, baby, personal care, essentials, kitchen & nutrition, and education & creativity) each year when you complete a behavioral health follow-up within 8-30 days after hospitalization for a behavioral health diagnosis.

Online Mental Health Resources

- Free 24/7 access to a secure online tool accessible through laptop, desktop, or mobile phone to help you learn ways to reduce stress, anxiety, or depression and how to manage substance use problems.
- Visit this website: https:// https://plan.carelonbehavioralhealth.com/

*****Restrictions and limitations may apply.*****

How can I get these benefits?

You do not have to go to your primary care provider to get these services. If you have questions or need help with these services, go to our website, **www.ParklandHealthPlan.com,** or call us at the toll-free number on your ID card.

What health education classes does PCHP offer?

We work with our community partners to make these classes available at no cost to you. Some health topics include:

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

Teen pregnancy awareness	Physical fitness	

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

What other services can PCHP help me get?
We can help you with services covered by fee-for-service Medicaid instead of PCHP. Listed below are agencies and programs that provide other services.

- Texas Health Steps dental (including orthodontia) — Medicaid members ages 20 and younger can get dental benefits through a dental managed care organization.
- Texas Health Steps environmental lead investigation (ELI).
- Texas Health Steps Personal Care Services for members birth through age 20.
- Early Childhood Intervention (ECI) case management/service coordination.
- ECI Specialized Skills Training.
- Texas School Health and Related Services (SHARS).
- Department of Assistive and Rehabilitative Services Blind Children's Vocational Discovery and Development Program.
- Tuberculosis services provided by Department of State Health Services (DSHS)-approved providers (directly observed therapy and contact investigation).
- Community First Choice (CFC) services

You **do not** have to go to your primary care provider to get these services. If you have questions or need help with these services, call us at the toll-free number on your ID card.

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.

Health Care and Other Services

What does medically necessary mean?
Medically Necessary means:

(1) For Members birth through age 20, the following Texas Health Steps services:
    (a) screening, vision, and hearing services; and

(b) other Health Care Services, including Behavioral Health Services, that are necessary to correct or ameliorate a defect or physical or mental illness or condition. A determination of whether a service is necessary to correct or ameliorate a defect or physical or mental illness or condition:
   (i) must comply with the requirements of the *Alberto N., et al. v. Traylor, et al*. partial settlement agreements; and
   (ii) may include consideration of other relevant factors, such as the criteria described in parts (2) (b-g) and (3) (b-g) of this definition.

(2) For Members over age 20, non-behavioral health related 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 handicap, 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 diagnoses of the conditions;
   (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

(3) For Members over age 20, 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.

What is routine medical care? How soon can I expect to be seen?

Routine care is non-emergency or non-urgent care that you receive from your primary care provider and/or other healthcare providers.

The primary care provider you picked is called your "medical home" and will help you with all your medical care. Your primary care provider will give you regular checkups and treat you when needed. Your primary care provider will order prescription drugs and medical supplies.

Your primary care provider will also send you to a specialist if needed. A specialist can be your primary care provider as decided by your primary care provider and PCHP.

It is important that you follow your primary care provider's advice and take part in decisions about your healthcare. When you need care, call your primary care provider's phone number on your ID card. The doctor's office or clinic will make an appointment for you. It is very important that you keep your appointments. If you cannot keep your appointment, please call your doctor to let him/her know. Your primary care provider should be able to see you within two (2) weeks after you ask for a routine care appointment or within eight (8) weeks after you ask for an appointment for a physical or a wellness checkup.

What is urgent medical care?

Another type of care is **urgent care**. There are some injuries and illnesses that are probably not emergencies but can turn into emergencies if they are not treated within 24 hours. Some examples are:

Minor burns or cuts	Earaches	Sore throat	Muscle sprains/strains

What should I do if my child or I need urgent medical care?

For urgent care, you should call your doctor's office even on nights and weekends. Your doctor will tell you what to do. In some cases, your doctor may tell you to go to an urgent care clinic. If your doctor tells you to go to an urgent care clinic, you don't need to call the clinic before going. You need to go to a clinic that takes Parkland Community Health Plan Medicaid. For help, call us toll-free at **1-888-672-2277**. You also can call our 24-Hour Nurse Line at **1-888-667-7890** or locally in the Dallas area at **214-266-8773** for help with getting the care you need.

How soon can I expect to be seen?

You should be able to see your doctor within 24 hours for an urgent care appointment. If your doctor tells you to go to an urgent care clinic, you do not need to call the clinic before going. The urgent care clinic must take Parkland Community Health Plan Medicaid.

What is emergency medical care? How soon can I expect to be seen?

Emergency Medical Care

Emergency medical care is provided for Emergency Medical Conditions and Emergency Behavioral Health Conditions.

Emergency Medical Condition means:

A medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical care could result in:

1. placing the patient's health in serious jeopardy;
2. serious impairment to bodily functions;

3. serious dysfunction of any bodily organ or part;
4. serious disfigurement; or
5. in the case of a pregnant women, serious jeopardy to the health of a woman 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 a prudent layperson possessing average knowledge of medicine and health:

1. requires immediate intervention or medical attention without which the Member would present an immediate danger to themselves or others; or
2. which renders the Member incapable of controlling, knowing, or understanding the consequences of their actions.

Emergency Services and **Emergency Care** means:
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 or Emergency Behavioral Health Condition, including post-stabilization care services.

Guidelines
You should be seen the same day if you need emergency care. We ask that you follow the guidelines below when you believe you need 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 health, call your primary care provider.
- If you or your child are experiencing a crisis related to a mental health or substance use concern, crisis care is available by calling Carelon Behavioral Health at **1-800-945-4644 where licensed clinicians are available to talk to you help you decide what services are best. They can help connect you to crisis services.**

Tell your primary care provider as soon as possible after getting treatment.

- As soon as your health condition is stabilized, the emergency facility should call your primary care 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 primary care provider as soon as possible.
- Some good reasons to go to the ER are:

Danger of losing life or limb	Uncontrolled diarrhea or vomiting	Poisoning or overdose of medicine	Choking or problems breathing
Possible broken bones	Very bad chest pains	Heavy bleeding	Serious injuries or burns
Fainting	Suddenly not being able to move (paralysis)	Victim of a violent attack (rape, mugging, stab, or gunshot wound)	You have thoughts of causing harm to yourself or others
About to deliver a baby			

Emergency dental care

Are emergency dental services covered by the health plan?
PCHP covers limited emergency dental services in a hospital or ambulatory surgical center, including payment for the following:

- Treatment for dislocated jaw
- Treatment for traumatic damage to teeth and supporting structures
- Removal of cysts
- Treatment of oral abscess of tooth or gum origin
- Hospital, physician, and related medical services such as drugs for any of the above conditions

What do I do if 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 **1-888-672-2277** or call **911**.

What is post stabilization?
Post-stabilization care services are services covered by Medicaid that keep your condition stable following emergency medical care.

How do I get medical care after my primary care provider's office is closed?
If you get sick at night or on a weekend and cannot wait to get medical care, call your primary care provider. Your primary care provider or another doctor is ready to help by phone 24 hours a day, 7 days a week. You may also call the Parkland 24-Hour Nurse Line at **1-888-667-7890 or 214-266-8773** to speak with a registered nurse to help you decide what to do.

Follow-up care after emergency
You might need follow-up care after you go to the emergency room. If so, make an appointment with your 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 at the hospital unless told to by your primary care provider.

Getting care when traveling

What if I get sick when I am out of town or traveling? What if I am out of state?
If you need medical care when traveling, call us toll-free at **1-888-672-2277** and we will help you find a doctor.

If you need emergency services while traveling, go to a nearby hospital, then call us toll-free at **1-888-672-2277**.

What if I am out of the country?
Medical services performed out of the country are not covered by Medicaid.

Specialty Care

What if I need to see a special doctor (specialist)?
Your primary care provider can send you to another doctor if you need a special type of care your primary care provider cannot offer. Your primary care provider will tell you if you need to see a specialist. Some specialist services require a prior authorization.

What is a prior authorization?
Prior authorization is an approval that Parkland Community Health Plan requires for certain services and medications. Some services need approval before they are given. The provider who is treating 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 STAR (Medicaid) 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 the specialist?
You should be able to see a specialist within 3 weeks for a routine appointment, or within 24 hours for urgent care appointments.

How can I ask for a second opinion?
You can get a second opinion about the use of any healthcare service from a network provider. If a network provider is not available, you 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 opinion, please call us at the toll-free number on your ID card.

What if my PCP wants me to see a provider that is not in the PCHP network?
If your PCP wants you to see a provider who is not in the 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 ensure prior authorization is obtained by your PCP to provide services. Call us at **1-888-672-2277** 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.

Behavioral Health

How do I get help if I have mental health, alcohol, or drug use problems?
Parkland Community Health Plan has partnered with Carelon Behavioral Health to manage 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 Carelon 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?
Carelon Behavioral Health 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. Carelon 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 **1-800-945-4644 with any behavioral health question.** You can also search Carelon's online provider directory to locate providers in your area
https://providersearch.carelonbehavioralhealth.com/#/provider/search/providers/124/

Do I need a referral for this?
You do not need a referral from your primary care provider. 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 Carelon's member website:
https://plan.carelonbehavioralhealth.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 Carelon Behavioral Health at 1-800-945-4644.

Medication Management is a service where your primary care provider or behavioral health provider prescribes medication to help treat symptoms of mental health or subnstance 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. There are also specific services that are available "in lieu of" or instead of inpatient, when safe and appropriate for the member. Members must agree to receive ILOS before the services are provided. The goal of in lieu of services is to prevent or reduce hospitalization.

In Lieu Of Services (ILOS) include:

<u>Inpatient Services in an Institution of Mental Disease (IMD):</u> Services include hospitalization at an IMD in lieu of an acute care inpatient hospital setting. Inpatient services in an IMD are to treat acute psychiatric conditions and are allowed for up to 15 calendar days per month for members aged 21-64 only.

<u>Partial Hospitalization Services:</u> Partial hospitalization services provide a structured day program of outpatient behavioral health services. Partial Hospitalization Programs (PHPs) may provide services for mental health, SUD, or both.

<u>Intensive Outpatient (IOP) Services:</u> Intensive outpatient services, also referred to as IOP services are generally less intensive than PHPs. They may be delivered for mental health, SUD, or both. Intensive outpatient services are organized non-residential services providing structured group and individual therapy, educational services, and life skills training which consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per Day.

<u>Coordination Specialty Care (CSC) Services:</u> CSC is designed to meet the needs of persons with an early onset of psychosis. Persons enrolled in CSC receive mental health services that are based on a comprehensive, recovery-oriented model of treatment for persons with first-episode psychosis. CSC utilizes a shared-decision making and team-based approach to develop a plan of care tailored to the individualized needs of the person. CSC services are for persons aged 15–30

who have a psychotic disorder diagnosed within the past two years and who live in the service area of a CSC provider.

Members may request ILOS services directly by contacting PCHP's material subcontractor Carelon Behavioral Health (Carelon) or providers of this service. Carelon will offer and coordinate in-lieu-of services with members, when clinically indicated, to avoid admissions to or support the transition out of higher levels of care to offer additional service options to members.

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.

Medications

How do I get my medications?
Medicaid pays for most medicine your doctor says you need. Your doctor will write a prescription so you can take it to the drugstore or may be able to send the prescription for you.

How do I find a network drugstore?

- You can find a network drugstore/pharmacy by visiting our website at www.ParklandHealthPlan.com and then searching for a drugstore/pharmacy in your area.
- Call Member Services toll-free at **1-888-672-2277** and ask the representative to help you find a network pharmacy in your area.

What if I go to a drugstore not in the network?
You may have to pay if you go to a drugstore that is not in the network. The pharmacy can call the pharmacy Help Desk's toll-free number on the back of your/your child's PCHP ID card.

What do I bring with me to the drugstore?
You will need to bring the prescription your doctor wrote for you. You will also need to show Your Texas Benefits Medicaid Card and your PCHP Plan ID card.

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 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) days 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/complaint process.

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 PCHP at **1-888-672-2277** for help with your medications and refills.

Who do I call if I have problems getting my medications?
If you have a problem getting your medications, call us at the toll-free number at the back of your ID card.

What if I can't get the medication my 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.

What if I lose my medication(s)?
If you lose your medication you should contact your local pharmacy to see if a refill is available. Lost or stolen medications are not a covered benefit. You will need to pay the cost of the medication. You can also call your doctor or clinic if there is no refill available.

What if I need my medications delivered to me?
Please visit the online pharmacy listing OR call Member Services at **1-888-672-2277** for pharmacies that offer delivery.

What if I need durable medical equipment (DME) or other products normally found in a drugstore?
Some durable medical equipment (DME) and products normally found in a drugstore are covered by Medicaid. For all Members, PCHP pays for nebulizers, ostomy supplies, and other covered supplies and equipment if they are medically necessary. For children (birth through age 20), PCHP also pays for medically necessary prescribed over-the-counter drugs, diapers, formula, and some vitamins and minerals.

Call **1-888-672-2277** for more information about these benefits.

Family Planning Services

How do I get family planning services?
Family planning services help you plan or control pregnancy. You do not need a referral from your primary care provider to receive family planning services or supplies. If you are under age 21, you do not have to get permission from your parent to get family planning services or supplies. You can get family planning services from your primary care provider, or you can go to any family planning provider who is in our provider directory. The services you can get include:

- A yearly check-up
- An office or clinic visit for a problem, counseling, or advice
- Laboratory tests
- Prescriptions and contraceptive supplies like birth control pills, diaphragms, and condoms
- Pregnancy testing
- Sterilization services (only if you are 21 years of age or older; Federal Sterilization Consent Form needed)

Do I need a referral for this?
You do not need a referral from your primary care provider to get family planning services or supplies.

Where do I find a family planning services provider?
You can find the location of family planning providers near you online at www.dshs.state.tx.us/famplan, or you can call PCHP at 1-888-672-2277 for help in finding a family planning provider.

Case Management for Children and Pregnant Women (CPW)

What is Case Management for Children and Pregnant Women (CPW)?
CPW is a Medicaid Program that provides health-related case management services to high-risk pregnant women and to children from birth through 20 years of age with a health condition/health risk.

Case Management for Children and Pregnant Women
Need help finding and getting services? You might be able to get a case manager to help you.

Who can get a case manager?
Children, teens, young adults (birth through age 20), and pregnant women who get Medicaid and:

- Have health problems, or
- Are at a high risk for getting health problems.

What do case managers do?
A case manager will visit with you and then:

- Find out what services you need.

- Find services near where you live.
- Teach you how to find and get other services.
- Make sure you are getting the services you need.

What kind of help can I get?
Case managers can help you:
- Get medical and dental services.
- Get medical supplies or equipment.
- Work on school or education issues.
- Work on other problems.

How can I get a case manager?

Contact PCHP for more information or call Texas Health Steps at **1-877-847-8377** (toll-free), Monday to Friday, 8am-8pm.
- PCHP Case Management: 1-888-672-2277
- PCHP website: www.parklandhealthplan.com

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?
No referral is needed, but if you have questions or need help with these services, call us at **1-888-672-2277.**

Where do I find an ECI provider?
To get information about ECI services and other resources, you can call the DARS Inquiries Line at **1-800-628-5115** or you can call us at **1-888-672-2277.** You can also search online for an ECI program near you. Go to **https://citysearch.hhsc.state.tx.us/**.

Service Coordination

What is STAR Service Coordination?
Service coordination, also known as case management, is a service that we offer to help you/your child and your/your child's doctors develop a plan to make sure that you/your child have access to and utilize medically necessary covered services, non-capitated services, and other services and supports, especially if you/your child have special healthcare needs.

PCHP has experienced nurses who can help you understand health conditions that you/your child may have, like:

- ✓ Asthma
- ✓ Diabetes
- ✓ Chronic obstructive pulmonary disease (COPD)
- ✓ Transplants
- ✓ Using the emergency room frequently
- ✓ Being in the hospital often
- ✓ Wounds that won't heal
- ✓ Multiple diseases or conditions

What will a Service Coordinator do for me?
Our nurses will help you/your child stay healthy and get you the care you need. We help you find care close to you. We will work with your doctor to improve your health. The goal of our program is to learn what information or services you need. We want you to become more independent with your health.

How can I talk with a Service Coordinator?
You don't need a referral from a doctor to talk to a case manager. Call Member Services at 1-888-672-2277 and ask to speak to a case manager. Case managers are available Monday through Friday from 8 a.m. to 5 p.m. local time. If one isn't available, you can leave a confidential voice mail.

How can I get Service Coordination?
If you/your child have special healthcare needs, like a serious ongoing illness, disability, or chronic or complex conditions and would like more information, contact the toll-free number on the back of your ID card. We can help you make an appointment with one of our doctors who cares for patients with special healthcare needs. We will also refer you to one of our case managers who will:

- ✓ Help you get the care and services you need.
- ✓ Develop a plan of care with the help of you and your/your child's doctor.
- ✓ Will follow your/your child's progress and make sure you are getting the care you need.
- ✓ Answer your healthcare questions.

Although our nurses can help you, we know you may not want this. If you don't want to be in the program, you can quit at any time by calling your/your child's nurse.

Texas Health Steps Checkups

What is Texas Health Steps? What services are offered by Texas Health Steps?
Texas Health Steps is the Medicaid healthcare program for STAR and STAR Kids children, teens, and young adults, birth through age 20.

Texas Health Steps gives your child:

- Free regular medical checkups starting at birth.
- Free dental checkups starting at 6 months of age.
- A case manager who can find out what services your child needs and where to get these services.

Texas Health Steps checkups:

- Find health problems before they get worse and harder to treat.
- Prevent health problems that make it hard for children to learn and grow like others their age.
- Help your child have a healthy smile.

How and when do I get Texas Health Steps medical and dental checkups for my child?

When to set up a checkup:

- You will get a letter from Texas Health Steps telling you when it's time for a checkup. Call your child's doctor or dentist to set up the checkup.
- Set up the checkup at a time that works best for your family.

If the doctor or dentist finds a health problem during a checkup, your child can get the care he or she needs, such as:

- Eye tests and eyeglasses
- Hearing tests and hearing aids
- Dental care
- Other healthcare
- Treatment for other medical conditions

Call PCHP or Texas Health Steps **1-877-847-8377** (**1-877-THSTEPS**) (toll-free) if you:

- Need help finding a doctor or dentist.
- Need help setting up a checkup.
- Have questions about checkups or Texas Health Steps.
- Need help finding and getting other services.

Why is it important to get Texas Health Steps checkup for my child within 90 days?

As a new member to PCHP, it is important for your child to see a provider within the first 90 days you are enrolled with us for a Texas Health Steps checkup. To avoid health problems for your children, teens, and young adults, make sure they get their Texas Health Steps medical and dental checkups.

Does my doctor have to be part of the PCHP network?

Members can go to any Texas Health Steps Provider. The Texas Health Steps Provider does not have to be a part of the PCHP network. This can include your primary care provider. If you go to a Texas Health Steps provider who is not your primary care provider, ask the Texas Health Steps provider to send a copy of your checkup results to your primary care provider.

Do I have to have a referral?
You do not need a referral from your primary care provider to get Texas Health Steps medical or dental checkups.

What if I need to cancel an appointment?
If you need to cancel or change your appointment for a Texas Health Steps checkup, please call your Texas Health Steps provider as soon as possible.

What if I am out of town and my child is due for a Texas Health Steps checkup?
It is important to schedule your child's checkup before you leave town. If you are out of town when the Texas Health Steps checkup is due, make an appointment with a Texas Health Steps provider as soon as you get home. If you have moved, please call PCHP at the toll-free number on your ID card to get the name of a Texas Health Steps provider close to where you live.

What if I am a migrant farm worker?
A migrant farm worker is a person who works on farms or fields or as a food packer during certain times of the year. Migrant farm workers move to different places to follow the crops.

You can get your checkup sooner if you are leaving the area. We have special Medicaid services for children of migrant farm workers. Call PCHP Member Services at 1-888-672-2277 if you have questions or need more information.

If you call us and tell us you are a migrant farm worker:
- We will help you find the doctors and clinics, and help you set up appointments for your children.
- We will let doctors know your children need to be seen quickly because you may have to leave the area to go to the next farm job.

Why does my health plan need to know if I am a migrant farm worker?
We want to make sure you get the care you need in a timely manner. If you travel doing seasonal work, we want to help you plan for getting checkups and other services that might be due while you are away.

How can your health plan help?
If you are a migrant farm worker, you can call us at **1-888-672-2277**. We can help you find out if you would be due for a checkup during the time you will be living outside the area. We will help you make a plan for getting services before you leave.

Nonemergency Medical Transportation Program (NEMT)

Access2Care

What is Access2Care?
NEMT services provide transportation to nonemergency healthcare appointments for Members who have no other transportation options. These trips include rides to the doctor, dentist, hospital, pharmacy, and other places you get Medicaid services. These trips do NOT include ambulance trips.

What services are part of Access2Care?

- Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus.
- Commercial airline transportation services.
- Demand response transportation services, which is curb-to-curb transportation in private buses, vans, or sedans, including wheelchair-accessible vehicles, if necessary.
- Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered healthcare service. The ITP can be you, a responsible party, a family member, a friend, or a neighbor.
- If you are 20 years old or younger, you may be able to receive the cost of meals associated with a long-distance trip to obtain healthcare services. The daily rate for meals is $25 per day for the member and $25 per day for an approved attendant.
- If you are 20 years old or younger, you may be able to receive the cost of lodging associated with a long-distance trip to obtain healthcare services. Lodging services are limited to the overnight stay and do not include any amenities used during your stay, such as phone calls, room service, or laundry service.
- If you are 20 years old or younger, you may be able to receive funds in advance of a trip to cover authorized NEMT services.

If you need an attendant to travel to your appointment with you, NEMT services will cover the transportation costs of your attendant.

Children 14 years old and younger must be accompanied by a parent, guardian, or other authorized adult. Children 15-17 years old must be accompanied by a parent, guardian, or other authorized adult or have consent from a parent, guardian, or other authorized adult on file to travel alone. Parental consent is not required if the healthcare service is confidential in nature.

How do I get a ride?
Your health plan will provide you with information on how to request services from Access2Care. You should request NEMT services as early as possible, and at least two business days before you need the NEMT service. In certain circumstances you may request the NEMT service with less notice. These circumstances include being picked up after being discharged from a hospital; trips to the pharmacy to pick up medication or approved medical supplies; and

trips for urgent conditions. An urgent condition is a health condition that is not an emergency but is severe or painful enough to require treatment within 24 hours.
You must notify your health plan prior to the approved and scheduled trip if your medical appointment is cancelled.

Vision Services

How do I get eye care services?
Avesis Vision will offer vision services like exams and glasses. Avesis Vision will help you get the care you need while coordinating with PCHP. If you need vision services, please call Avesis Vision at **1-866-678-7113**.

For routine eye exams you can visit an eye care doctor without a referral from your primary care provider. You can pick an eye doctor that is close to you. Vision services are different for adults and children.

Children, teens, and young adults, birth through age 20, can get an eye exam and prescription eyeglasses once during a 12-month period. You may be able to get more services if there is a change in your vision. You may be able to get more services if they are requested in writing by the child's primary care provider, teacher, or school nurse.

If you are age 21 or over, you can get an eye exam once every 24 months.

Dental Services

What dental services does PCHP cover for children?
PCHP covers emergency dental services in a hospital or ambulatory surgical center, including, but not limited to, payment for the following:

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

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

PCHP is also responsible for paying for treatment and devices for craniofacial anomalies.

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

Interpreter Services

Can someone interpret for me when I talk with my doctor? Who do I call for an interpreter?
At any time during your healthcare experience, if you need help with special language services including interpreters, we have a language line to assist. Call Member Services at **1-888-672-2277** for interpreter services. At the time of your call, we will get a language interpreter who speaks your language on the line. People who are deaf or hearing impaired can call the TTY line 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 also 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 us at the toll-free number on your ID card. We need 72 hours advance notice of a need for an interpreter.

Women's Health

What if I need OB/GYN care? Do I have the right to choose an OB/GYN?
Attention female members - PCHP allows you to pick an OB/GYN, but this doctor must be in the same network as your primary care provider.

You have the right to pick an OB/GYN without a referral from your 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 doctors within the network

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

If I do not choose an OB/GYN, do I have direct access?
You can contact any OB/GYN in the PCHP network directly to receive services.

Will I need a referral?
You have the right to pick an OB/GYN from our network without a referral from your primary care provider.

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

Can I stay with my OB/GYN if they are not with PCHP?
If you are pregnant and are past the 24th week of your pregnancy when you join, you will be able to stay under the care of your current OB/GYN. If you want, you can pick an OB/GYN who is in our network as long as the provider agrees to treat you. We can help with the changes between doctors.

What if I am pregnant? Who do I need to call?
First, call your primary care provider. Your primary care provider can help you get the care you need for your pregnancy. You should also call your Medicaid caseworker to let them know that you are pregnant. Don't forget to call PCHP to let us know that you will be having a baby.

If you do not have an OB/GYN, we will help you find a doctor within two (2) weeks after you ask us to help you.

You should keep all of your prenatal appointments. This will help keep your baby healthy. Remember to get all your checkups after you have your baby. You should be seen by an OB/GYN within 2 weeks after you ask for the appointment. If you would like to take prenatal classes, you can call PCHP Member Services at **1-888-672-2277** to find classes near you.

Call PCHP Member Services at **1-888-672-2277** for more information.

What other services/activities/education does PCHP offer pregnant women?
PCHP has a special program to keep you and your baby healthy while you are pregnant. PCHP offers free gifts to members who take and complete prenatal and postpartum checkups.

Call PCHP Member Services at **1-888-672-2277** for more information.

Where can I find a list of birthing centers?
Please contact Member Services at **1-888-672-2277,** or you can search our provider directory online at www.ParklandHealthPlan.com to find out which birthing centers are in our network.

Can I pick a primary care provider for my baby before the baby is born?
You should call us before your baby is born or as soon as possible to pick a pediatrician (baby doctor). You will be able to pick your baby's doctor from a list of doctors in the PCHP provider directory.

How and when can I switch my baby's primary care provider?
To change your baby's primary care provider, call us at the toll-free number on your ID card. We can change your baby's primary care provider on the same day you ask for the change. The change will be effective immediately.

Can I switch my baby's health plan?
For at least 90 days from the date of birth, your baby will be covered by the same health plan that you are enrolled in. You can ask for a health plan change before the 90 days is up by calling the Enrollment Broker at **1-800-964-2777**.

You cannot change health plans while your baby is in the hospital.

How do I sign up my newborn baby? How and when do I tell my health plan?
It is important that you call us at the toll-free number on your ID card as soon as possible so we can make sure you know about the health services for your baby.

How can I receive healthcare after my baby is born (and I am no longer covered by Medicaid)?
After your baby is born you may lose Medicaid coverage. You may be able to get some healthcare services through the Healthy Texas Women Program and the Department of State Health Services (DSHS). These services are for women who apply for the services and are approved.

How and when do I tell my caseworker?
You will need to contact your Medicaid caseworker as soon as your baby is born to enroll your baby in Medicaid.

Texas Women's Health Program

The Healthy Texas Women Program provides family planning exams, related health screenings, and birth control to women ages 18 to 44 whose household income is at or below the program's income limits (185 percent of the federal poverty level). You must submit an application to find out if you can get services through this program.

To learn more about services available through the Healthy Texas Women Program, write, call, or visit the program's website:

Healthy Texas Women Program
P.O. Box 14000
Midland, TX 79711-9902
Phone: **1-800-335-8957**
Website: **www.texaswomenshealth.org/**
Fax (toll-free): **1-866-993-9971**

DSHS Primary Health Care Program

The DSHS Primary Health Care Program serves women, children, and men who are unable to access the same care through insurance or other programs. To get services through this program, a person's income must be at or below the program's income limits (200 percent of the federal poverty level). A person approved for services may have to pay a co-payment, but no one is turned down for services because of a lack of money.

Primary Health Care focuses on prevention of disease, early detection, and early intervention of health problems. The main services provided are:

- Diagnosis and treatment
- Emergency services
- Family planning
- Preventive health services, including vaccines (shots) and health education, as well as laboratory, x-ray, nuclear medicine, or other appropriate diagnostic services.

Secondary services that may be provided are nutrition services, health screening, home healthcare, dental care, rides to medical visits, medicines your doctor orders (prescription drugs), durable medical supplies, environmental health services, treatment of damaged feet (podiatry services), and social services.

You will be able to apply for Primary Health Care services at certain clinics in your area. To find a clinic where you can apply, visit the DSHS Family and Community Health Services Clinic Locator at **http://txclinics.com/.**

To learn more about services you can get through the Primary Health Care program, email, call, or visit the program's website:

Website: **www.dshs.state.tx.us/phc/**
Phone: **512-776-7796**
Email: **PPCU@dshs.state.tx.us**

DSHS Expanded Primary Health Care Program
The Expanded Primary Health Care program provides primary, preventive, and screening services to women age 18 and above whose income is at or below the program's income limits (200 percent of the federal poverty level). Outreach and direct services are provided through community clinics under contract with DSHS. Community health workers will help make sure women get the preventive and screening services they need. Some clinics may offer help with breastfeeding.

You can apply for these services at certain clinics in your area. To find a clinic where you can apply, visit the DSHS Family and Community Health Services Clinic Locator at http://txclinics.com/.

To learn more about services you can get through the DSHS Expanded Primary Health Care program, visit the program's website, call, or email:

Website: **www.dshs.state.tx.us/ephc/Expanded-Primary-Health-Care.aspx**
Phone: **512-776-7796**
Fax: **512-776-7203**
Email: **PPCU@dshs.state.tx.us**

DSHS Family Planning Program
The Family Planning Program has clinic sites across the state that provide quality, low-cost, and easy-to-use birth control for women and men.

To find a clinic in your area visit the DSHS Family and Community Health Services Clinic Locator at http://txclinics.com/.

To learn more about services you can get through the Family Planning program, visit the program's website, call, or email:

Website: **www.dshs.state.tx.us/famplan**
Phone: **512-776-7796**
Fax: **512-776-7203**
Email: **PPCU@dshs.state.tx.us**

Special Health Care Needs

Who do I call if I have special healthcare needs and need someone to help me?

Case Managers are ready to help you if you have special healthcare 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 healthcare delivery system. The program is designed to ensure that the care delivered is appropriate, medically necessary, and aligned with the best and most accurate clinical practices.

Preservice review
Pre-authorization is 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 Provider will submit pre-authorization requests 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 concurrent review is a request for coverage of medical care or services made while you are in the process of receiving care or services, even if PCHP did not previously approve the care. All concurrent requests are considered urgent and are typically associated with inpatient care, residential behavioral healthcare, intensive outpatient behavioral healthcare, and ongoing ambulatory care. 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.

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

Call: PCHP– 1-888-672-2277
Fax: 1-844-310-1823

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

Email: PCHPComplaintsandAppeals@phhs.org

For more information, please review the member handbook or contact Member Services at 1-888-672-2277.

Medical Care Decisions

What if I am too sick to make a decision about my medical care? What are advance directives? How do I get an advance directive?

An advance directive is a written statement that you complete before a serious illness. This statement tells how you want medical decisions made. If you can't make treatment decisions, your doctor will ask your closest relative or friend to help you decide what is best for you. Sometimes everyone doesn't agree about what to do. That's why it is helpful if you tell us in advance what you want to happen if you can't speak for yourself. If you do not have an advance directive and you would like more information on how to get one, call us at the toll-free number on your ID card. We will be glad to help you.

Renewal Process

What do I have to do if I need help with completing my renewal application?

Families must renew their child's Medicaid coverage every year. In the months before a child's coverage is due to end, HHSC will send you a letter telling you it's time to renew your Medicaid benefits. The letter will have instructions to tell you how to renew. If you don't renew by the date in the letter, you'll lose your health care benefits.

We want you to keep getting your health benefits from us if you still qualify. You can apply for and renew your benefits online at www.yourtexasbenefits.com. Click on Manage Your Account and set up an account to get easy access to the status of your benefits.

If you have any questions or would like to find the HHSC office near you, you can call 2-1-1, pick a language, and then select option 2. You can visit the HHSC benefits office near you or go to www.yourtexasbenefits.com and click on Find an Office at the bottom of the page.

What happens if I lose my Medicaid coverage?
If you lose Medicaid coverage but get it back again within six (6) months, you will get your Medicaid services from the same health plan you had before losing your Medicaid coverage. You will also have the same primary care provider you had before.

What if I get a bill from my doctor? Who do I call? What information will they need?
If the bill is for a Medicaid covered service, you will not have to pay. Call us at the toll-free number on your ID card if you get a bill in the mail from your doctor. We will call the doctor's office for you to explain your benefits and arrange for your bill to be paid. When you call us, please have your PCHP ID card, Your Texas Benefits Medicaid Card, and the doctor's bill with you. We will need this information so we can help you quickly.

What do I have to do if I move?
As soon as you have your new address, give it to the local HHSC benefits office and PCHP's Member Services Department at **1-888-672-2277**. Before you get Medicaid 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.

If you are an AA/PCA member and need to change your address or phone number:

- The adoptive parent or permanency care assistance caregiver should contact the DFPS regional adoption assistance eligibility specialist assigned to his or her case.
- If the parent or caregiver doesn't know who the assigned eligibility specialist is, they can contact the DFPS hotline, **1-800-233-3405**, to find out.
- The parent or caregiver should contact the adoption assistance eligibility specialist to assist with the address change.

What if I have other health insurance in addition to Medicaid?
Medicaid and Private Insurance
You are required to tell Medicaid staff about any private health insurance you have. You should call the Medicaid Third Party Resources hotline and update your Medicaid case file if:

- Your private health insurance is cancelled.
- You get new insurance coverage.
- You have general questions about third-party insurance.

You can call the hotline toll-free at **1-800-846-7307**.

If you have other insurance, you may still qualify for Medicaid. When you tell Medicaid staff about your other health insurance, you help make sure that Medicaid only pays for what your other health insurance does not cover.

IMPORTANT: Medicaid providers cannot turn you down for services because you have private health insurance as well as Medicaid. If providers accept you as a Medicaid patient, they must also file with your private health insurance company.

Quick Tips and Member Safety

When should I 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, or sore throat
- When you have a minor injury, burn, or cut
- For 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, or sore throat
- When you have a minor injury, burn, or cut

Go to the Emergency Room

- If you are having a hard time breathing
- When bleeding does not stop
- For poisoning
- For broken bones
- For an asthma attack
- When you have passed out (fainted)
- For 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 Medicaid dental plan includes services that prevent tooth decay and fix dental problems. You do not need a referral from 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, 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 lasts more than 24 hours
Over 4 months old	103	Call your PCP if the fever lasts more than 2 days after giving medicine

Member Rights and Responsibilities

***What are my rights and responsibilities*?**

Member Rights:

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
    a. Be treated fairly and with respect.
    b. Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a healthcare plan and Primary Care Provider. This is the doctor or healthcare provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
    a. Be told how to choose and change your health plan and your Primary Care Provider.
    b. Choose any health plan you want that is available in your area and choose your Primary Care Provider from that plan.
    c. Change your Primary Care Provider.
    d. Change your health plan without penalty.
    e. Be told how to change your health plan or your Primary Care Provider.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
    a. Have your provider explain your healthcare needs to you and talk to you about the different ways your healthcare problems can be treated.
    b. Be told why care or services were denied and not given.
    c. Be given information about your health, plan, services, and providers.

    d. Be told about your rights and responsibilities.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
    a. Work as part of a team with your provider in deciding what healthcare is best for you.
    b. Say yes or no to the care recommended by your provider.
5. You have the right to use each complaint and appeal process available through your health plan and through Medicaid, and get a timely response to complaints, appeals, and External Medical Reviews and State Fair Hearings.. That includes the right to:
    a. Make a complaint to your health plan or to the state Medicaid program about your healthcare, your provider, or your health plan.
    b. Get a timely answer to your complaint.
    c. Use the plan's appeal process and be told how to use it.
    d. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
    e. Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and receive information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
    a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
    b. Get medical care in a timely manner.
    c. Be able to get in and out of a healthcare provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
    d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
    e. Be given information you can understand about your health plan rules, including the Health Care Services you can get and how to get them.
7. 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.
8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your 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.
9. You have a right to know that you are not responsible for paying for Covered Services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for Covered Services.
10. You have a right to make recommendations to your health plan' member rights and responsibilities.

Member responsibilities:

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
    a. Learn and understand your rights under the Medicaid program.
    b. Ask questions if you do not understand your rights.
    c. Learn what choices of health plans are available in your area.
2. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:
    a. Learn and follow your health plan's rules and Medicaid rules.
    b. Choose your health plan and a Primary Care Provider quickly.
    c. Make any changes in your health plan and Primary Care Provider in the ways established by Medicaid and by the health plan.
    d. Keep your scheduled appointments.
    e. Cancel appointments in advance when you cannot keep them.
    f. Always contact your Primary Care Provider first for your non-emergency medical needs.
    g. Be sure you have approval from your Primary Care Provider before going to a specialist.
    h. Understand when you should and should not go to the emergency room.
3. You must share information about your health with your Primary Care Provider and learn about service and treatment options. That includes the responsibility to:
    a. Tell your Primary Care Provider about your health.
    b. Talk to your providers about your healthcare needs and ask questions about the different ways your healthcare problems can be treated.
    c. Help your providers get your medical records.
4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to keep yourself healthy. That includes the responsibility to:
    a. Work as a team with your provider in deciding what healthcare is best for you.
    b. Understand how the things you do can affect your health.
    c. Do the best you can to stay healthy.
    d. Treat providers and staff with respect.
    e. Talk to your provider about all your medications.

Additional Member Responsibilities while using Access2Care:

1. When requesting NEMT Services, you must provide the information requested by the person arranging or verifying your transportation.
2. You must follow all rules and regulations affecting your NEMT services.
3. You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.
5. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets or tokens only to go to your medical appointment.

6. You must only use NEMT Services to travel to and from your medical appointments.
7. If you have arranged for an NEMT Service but something changes, and you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible.

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.**

Complaint Process

What should I do if I have a complaint? Who do I call to help me with filing a complaint?
We want to help. If you have a complaint, please call us toll-free at **1-888-672-2277** to tell us about your problem. A PCHP Member Services Advocate can help you file a complaint. Just call **1-888-672-2277**. Most of the time, we can help you right away or, at the most, within a few days.

Once you have gone through the PCHP complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling toll-free 1-866-566-8989.

If you would like to make your complaint in writing, please send it to the following address:

Texas Health and Human Services Commission
Ombudsman Managed Care Assistance Team
P.O. Box 13247
Austin, Texas 78711-3247

If you have internet access, you can submit your complaint at:
hhs.texas.gov/managed-care-help.

Can someone from PCHP help me file a complaint?
Our Member Services Representative can help you file a complaint. You can also send a written complaint to:

Parkland Community Health Plan
Attention: Complaints and Appeals Department
P.O. Box 560347
Dallas, TX 75356
1-888-672-2277

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.
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.

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.

Appeal Process

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

PCHP will send you a letter about an adverse benefit determination on a covered service that your doctor requests. An adverse benefit determination means the denial or limited authorization of a requested service. It includes:

- the denial in whole or part of payment for a service
- the denial of a type or level of service
- the reduction, suspension, or termination of a previously authorized service

You have the right to ask for an appeal if you are not happy or disagree with the adverse benefit determination. 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. 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:

Parkland Community Health Plan
Attention: Appeals Department
P.O. Box 560347
Dallas, TX 75356

How will I find out if services are denied?

If your services are denied, you and your doctor will get a letter that tells you the reason for denial. The letter will tell you how to file an appeal and how to ask for a State Fair Hearing with or without an External Medical Review.

What are the timeframes for the appeal process?
Your request for an appeal must be filed within sixty (60) days from the date of the notice of the adverse benefit determination. To ensure continuity of currently authorized services, you must file the appeal on or before the later of

1. 10 days following PCHP mailing of the notice of the action or
2. the day the health plan's letter says your service will be reduced or end

The timeframe for the resolution of the appeal will depend on what services have been denied. If you are in the hospital or delay in resolution will cause harm to your life or health or your ability to attain, maintain or regain maximum functionality, you can call and ask for an expedited appeal. The expedited appeal process is explained below.

Your request for an appeal can be verbal or in writing. If the appeal is received verbally, the Member Services Representative will write down the information and send it to you for review. You will need to return the form to:

Parkland Community Health Plan
Attention: Appeals Department
P.O. Box 560347
Dallas, TX 75356

The resolution of your appeal can be extended up to fourteen (14) calendar days of the appeal if you ask for more time, or if PCHP can show that we need more information. We can only do this if more time will help you. We will send you a letter telling you why we asked for more time.

For a standard appeal, we will send you a letter within five (5) days of receiving the request for an appeal. This letter is to let you know that your request came to us. PCHP will send all information we have to a doctor who was not part of making the first decision. You will get a written response on your appeal within thirty (30) days after your appeal was sent to us. \

You can ask for a State Fair Hearing with or without an External Medical Review no later than 120 Days after the date on Parkland Community Health Plan (PCHP) appeal decision notice.

You have the option to request only a State Fair Hearing Review no later than 120 Days after PCHP's appeal decision notice.

A State Fair Hearing with or without an External Medical Review can only be requested once the PCHP Appeal process has been completed.

When do I have the right to ask for an appeal?
If you don't agree with the decision made by PCHP about a benefit or service, including denial for payment of services in whole or in part, you can ask PCHP for an appeal. You do not have a right to an appeal if the services you requested are not covered under Medicaid. You do not have a right to an appeal if a change is made to the state or federal law, which affects some or all of Medicaid recipients.

Does my request have to be in writing?
Your request does not have to be in writing. You can ask for an appeal by Member Services at 1-888-672-2277. We will write down what you tell us and send it to you to review. Every verbal appeal must be confirmed by a written, signed Appeal form by the member or his or her representative, unless an expedited appeal is requested.

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 on your ID card or writing to:

Parkland Community Health Plan
Attention: Appeals Department
P.O. Box 560347
Dallas, TX 75356

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 the 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 at the toll-free number on your ID card or writing to:

Parkland Community Health Plan
Attention: Appeals Department
P.O. 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 our Member Services Department.

What are the timeframes for an emergency (expedited) appeal?
The timeframe for resolution will be based on your medical emergency condition, procedure, or treatment. PCHP will let you know the final decision of the emergency (expedited) appeal in writing within twenty-four (24) hours.

What happens if PCHP denies the request for an emergency (expedited) appeal?
If you ask for an emergency (expedited) appeal that does not involve an emergency condition, procedure or treat or an ongoing hospitalization, you will be told that the appeal cannot be rushed. A written notice of the denial will be sent within two days of receipt of the request. We will continue to work on the appeal within the standard timeframe and respond to you within thirty (30) days from the time the appeal was received.

Wo can help me in filing an emergency (expedited) appeal?
You can ask for an appeal by calling us at the toll-free number on your ID card or writing to:

Parkland Community Health Plan
Attention: Appeals Department
P.O. Box 560347
Dallas, TX 75356

External Medical Review

Can a Member ask for an External Medical Review?

If a Member, as a member of the health plan, disagrees with the health plan's internal appeal decision, the Member has the right to ask for an External Medical Review. An External Medical Review is an optional, extra step the Member can take to get the case reviewed before the State Fair Hearing occurs. The Member may name someone to represent them by contacting the health plan and giving the name of the person the Member wants to represent him or her. A provider may be the Member's representative.

The Member or the Member's representative must ask for the External Medical Review within 120 days of the date the health plan mails the letter with the internal appeal decision. If the Member does not ask for the External Medical Review within 120 days, the Member may lose his or her right to an External Medical Review. To ask for an External Medical Review, the Member or the Member's representative may either:

- Fill out the 'State Fair Hearing and External Medical Review Request Form' provided as an attachment to the Member Notice of MCO Internal Appeal Decision letter and mail or fax it to PCHP by using the address or fax number at the top of the form;
- Call PCHP at 1-888-672-2277;
- Email the PCHP at PCHPComplaintsandAppeals@phhs.org

If the Member asks for an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the Member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final State Fair Hearing decision is made. If the Member does not request an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the service the health plan denied will be stopped.

The Member may withdraw the Member's request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the Member's External Medical Review request. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an External Medical Review during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. The Member may withdraw a State Fair Hearing request orally or in writing by contacting the hearings officer listed on Form 4803, Notice of Hearing.

If the Member continues with a State Fair Hearing and the State Fair Hearing decision is different from the Independent Review Organization decision, it is the State Fair Hearing decision that is final. The State Fair Hearing decision can only uphold or increase Member benefits from the Independent Review Organization decision.

Can I ask for an emergency External Medical Review?

If you believe that waiting for a standard External Medical Review will seriously jeopardize your life or health, or your ability to attain, maintain, or regain maximum function, you, your parent or your legally authorized representative may ask for an emergency External Medical Review and emergency State Fair Hearing by writing or calling PCHP. To qualify for an emergency External Medical Review and emergency State Fair Hearing review through HHSC, you must first complete PCHP's internal appeals process.

State Fair Hearing

Can I ask for a State Fair Hearing?

If you, as a Member of the health plan, disagree with the health plan's internal appeal decision, you have the right to ask for a State Fair Hearing. You may name someone to represent you by writing a letter to the health plan telling them the name of the person you want to represent you. A provider may be your representative.

If you want to challenge a decision made by your health plan, you or your representative must ask for the State Fair Hearing within 120 days of the date on the health plan's letter with the internal appeal decision. If you do not ask for the State Fair Hearing within 120 days, you may lose your right to a State Fair Hearing.

To ask for a State Fair Hearing, you or your representative should either call **1-888-672-2277 or** send a letter to the health plan:

Parkland Community Health Plan
Attention: Complaints and Appeals Department
P.O. Box 560347
Dallas, TX 75356

You have the right to keep getting any service the health plan denied or reduced, at least until the final hearing decision is made, if you ask for a fair hearing by the later of:

1. 10 calendar days following the date on the health plan's internal appeal decision letter, or

2. the day the health plan's internal appeal decision letter says your service will be reduced or end.

If you do not request a State Fair Hearing by this date, the service the health plan denied will be stopped.

If you ask for a State Fair Hearing, you will get a packet of information letting you know the date, time, and location of the State Fair Hearing. Most State Fair Hearings are held by telephone. At that time, you or your representative can tell why you need the service the health plan denied.

HHSC will give you a final decision within 90 days from the date you asked for the hearing.

Can I ask for an emergency State Fair Hearing?

If you believe that waiting for a State Fair Hearing will seriously jeopardize your life or health, or your ability to attain, maintain, or regain maximum function, you or your representative may ask for an emergency State Fair Hearing by writing or calling PCHP. To qualify for an emergency State Fair Hearing through HHSC, you must first complete PCHP's internal appeals process.

Fraud and Abuse Information

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

Let us know if you think a doctor, dentist, pharmacist at a drugstore, other healthcare providers, or a person getting 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 services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Medicaid ID.
- Using someone else's Medicaid 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:

- Call the OIG Hotline at **1-800-436-6184**;
- Visit **https://oig.hhsc.state.tx.us; u**nder the box labeled "I WANT TO," click "Report Waste, Abuse, and Fraud" to complete the online form; or
- You can report directly to your health plan:

Mail: Parkland Community Health Plan
Attention: SIU Analyst
P.O. Box 560347
Dallas, TX 75356
Phone: 1-800-403-2498
Email: PCHPSIU@phhs.org

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 the provider
- 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 the number 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.

Annual Notification

The following information must be made available to Members on an annual basis (Balanced Budget Act requirement). This should be stated as below:

As a Member of PCHP, you can ask for and get the following information each year:

1. Information about Network Providers – at a minimum, primary care doctors, specialists, and hospitals in our service area. This information will include names, addresses, telephone numbers, and languages spoken (other than English) for each Network Provider, plus identification of Providers that are not accepting new patients.
2. Any limits on your freedom of choice among Network Providers.
3. Your rights and responsibilities.
4. Information on complaint, appeal, External Medical Review and State Fair Hearing procedures.
5. Information about benefits available under the Medicaid program, including amount, duration, and scope of benefits. This is designed to make sure you understand the benefits to which you are entitled.
6. How you get benefits including authorization requirements.
7. How you get benefits, including family planning services, from Out-of-Network providers and limits to those benefits.
8. How you get after-hours and emergency coverage and limits to those kinds of benefits, including:
    - What makes up Emergency Medical Conditions, Emergency Services, and Post-Stabilization Services.
    - The fact that you do not need prior authorization from your Primary Care Provider for emergency care services.
    - How to get Emergency Services, including instructions on how to use the 911 telephone system or its local equivalent.

    - The addresses of any places where providers and hospitals furnish Emergency Services covered by Medicaid.
    - A statement saying you have a right to use any hospital or other settings for emergency care.
    - Post-stabilization rules.
9. Policy on referrals for specialty care and for other benefits you cannot get through your Primary Care Provider.
10. PCHP practice guidelines.

Subrogation

We can ask for reimbursement 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 can be responsible for) causing the illness or injury to you. We can also 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 healthcare service, usually when you receive the service. The amount can vary by the type of covered healthcare service.
Durable Medical Equipment (DME) - Equipment and supplies ordered by a healthcare 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 - Healthcare 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 - Healthcare 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 healthcare costs in exchange for a premium.
Home Health Care - Healthcare 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 - Healthcare 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 healthcare 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 when 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 - Healthcare 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 healthcare 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. Pre-authorization 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 healthcare 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 healthcare services.
Provider - A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), healthcare professional, or healthcare facility licensed, certified, or accredited as required by state law.
Rehabilitation Services and Devices - Healthcare 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.

Personal Information

My STAR (Medicaid) member ID number is:

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My Child's Primary Care Provider (PCP) is:

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My Child's Primary Care Provider's address is:

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My Child's Primary Care Provider's telephone number is:

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Parkland
Community Health Plan