Amerigroup
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Member Handbook

Amerigroup Community Care, Tennessee

TennCare — 1-800-600-4441 (TTY 711)

CHOICES and Employment and
Community First CHOICES — 1-866-840-4991 (TTY 711)

www.myamerigroup.com/TN

TN-MHB-0022-18

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Employment and Community First CHOICES – 1-866-840-4991 (TTY 711)

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TN-MHB-0022-18 4.18

FREE Phone Numbers to call for help	
Amerigroup Community Care call about your health care	**1-800-600-4441**
Amerigroup CHOICES in Long-Term Services and Support call to apply for CHOICES or to speak to your Care Coordinator	**1-866-840-4991**
Amerigroup Employment and Community First CHOICES call if you need help to complete a self-referral or to speak to your Support Coordinator	**1-866-840-4991**
Nurse Help Line -	**1-866-864-2544**
DentaQuest call about dental (teeth) care for children under age 21 or adults enrolled in Employment and Community First CHOICES	**1-855-418-1622**
TennCare Pharmacy Program call about TennCare pharmacy services	**1-888-816-1680**
Tennessee Health Connection call about: • change of address, job, or income • TennCare co-pays • appeals to get or keep TennCare • applying for TennCare • programs like Food Stamps or Families First	**1-855-259-0701**
TennCare Advocacy Program call for help with physical health services or for help with Behavioral Health Services (mental health, alcohol, and drug abuse services)	**1-800-758-1638** TTY/TDD Line: **1-877-779-3103**
TennCare Solutions Unit call about problems getting health care, problems getting services in CHOICES and Employment and Community First CHOICES, or to file a medical appeal	**1-800-878-3192** TTY/TDD Line: **1-866-771-7043**
Medicare Information and Assistance Line call about Medicare	**1-800-633-4227**
SHIP Help Line call for help with Medicare	**1-877-801-0044**
Social Security Administration call about Social Security and Disability	**1-800-772-1213**
Office of Inspector General (OIG) call to report TennCare fraud or abuse	**1-800-433-3982**
Transportation Services call for a ride to get health care if you don’t have a way to get there	**1-866-680-0633**

Doctors’ Names	Phone Numbers

TennCare and
Your health plan, Amerigroup Community Care

Member Handbook
2018

¿Necesita un manual de TennCare en español? Para conseguir un manual en español, llame a **Amerigroup** al **1-800-600-4441.**

Your Right to Privacy

There are laws that protect your privacy. They say we can’t tell others certain facts about you. Read more about your privacy rights in Part 7 of this handbook.

Important!

Even if you don’t use your TennCare, the state still pays for you to have it. If you don’t need your TennCare anymore, please call the Tennessee Health Connection for free at **1-855-259-0701.**

Do you need free help with this letter?
If you speak a language other than English, help in your language is available for free. This page tells you how to get help in a language other than English. It also tells you about other help that's available.

Spanish: **Español**
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-600-4441 (TTY:711).

Kurdish: **ک وردی**
ئاگاداری: ئەگەر بە زمانی کوردی قەسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆڕایی، بۆ تۆ بەردەستە. پەیوەندی بە 1-800-600-4441 (TTY:711)..بکە

Arabic: **الـ عربـ ية**
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-600-4441 (TTY:711).(رقم هاتف الصم والبكم)

Chinese: **繁體中文**
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-600-4441 (TTY:711).

Vietnamese: **Tiếng Việt**
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-600-4441 (TTY:711).

Korean: 한국어
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-600-4441 (TTY:711).번으로 전화해 주십시오.

French: **Français**
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-600-4441 (TTY:711).

Amharic: **አማርኛ**
ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-600-4441 (መስማት ለተሳናቸው:TTY:711).

Gujarati: ગુજરાતી
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો
1-800-600-4441 (TTY:711) .

Laotian: **ພາສາລາວ**
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-600-4441 (TTY:711).

German: **Deutsch**
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-600-4441 (TTY:711).

Tagalog: **Tagalog**
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-600-4441 (TTY:711).

Hindi: **हिंदी**
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।1-800-600-4441 (TTY:711) . पर कॉल करें।

Serbo-Croatian: **Srpsko-hrvatski**
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-600-4441 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Russian: **Русский**
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
Звоните 1-800-600-4441 (телетайп: TTY:711).

Nepali: **नेपाली**
ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-600-4441 (टिटिवाइ: TTY:711).

Persian: ف ار سی
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-600-4441 (TTY:711) تماس بگیرید.

- Do you need help talking with us or reading what we send you?
- Do you have a disability and need help getting care or taking part in one of our programs or services?
- Or do you have more questions about your health care?

Call us for free at 1-800-600-4441. We can connect you with the free help or service you need. (For TTY call: 711)

We obey federal and state civil rights laws. We do not treat people in a different way because of their race, color, birth place, language, age, disability, religion, or sex. Do you think we did not help you or you were treated differently because of your race, color, birth place, language, age, disability, religion, or sex? You can file a complaint by mail, by email, or by phone. Here are three places where you can file a complaint:

<table>
<tr>
<td>TennCare
Office of Civil Rights Compliance
310 Great Circle Road, 3W
Nashville, Tennessee 37243

Email: HCFA.Fairtreatment@tn.gov
Phone: 855-857-1673
(TRS 711)

You can get a complaint form online at:
https://www.tn.gov/content/dam/tn/tenncare/documents/complaintform.pdf</td>
<td>Amerigroup
Nondiscrimination Coordinator
22 Century Blvd., Suite 220
Nashville, TN 37214

Email:
tn.nondiscrimination@amerigroup.com

Phone: 1-800-600-4441
(TTY 711)
Fax: 1-866-796-4532</td>
<td>U.S. Department of Health & Human Services
Office for Civil Rights
200 Independence Ave SW, Rm 509F, HHH Bldg
Washington, DC 20201

Phone: 800-368-1019
(TDD): 800-537-7697
You can get a complaint form online at:
http://www.hhs.gov/ocr/office/file/index.html
Or you can file a complaint online at:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</td>
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Welcome to TennCare and your health plan, Amerigroup

This is your TennCare member handbook. This handbook tells you how to use your TennCare to get care. TennCare is Tennessee's program for health care. It works like health insurance to help pay for many health care services.

There are two kinds of TennCare: **TennCare Medicaid and TennCare Standard.** You have either TennCare Medicaid or TennCare Standard. The difference is in the way that you got your TennCare.

TennCare Medicaid is the kind of TennCare that most people have. The rules for TennCare Medicaid say your income and sometimes your resources have to be looked at. Resources are things that you own or money you have saved.

You also have to be in a certain "group," like children under age 21 or pregnant women.

In Tennessee, people who get SSI (Supplemental Security Income) benefits get TennCare Medicaid, too. You can apply for SSI benefits at the Social Security office.

Some people have TennCare Medicaid **and** other insurance. Most of the time, that's OK. The federal government says you can have Medicaid and other insurance as long as you meet the rules for Medicaid. Do you have TennCare Medicaid because you are enrolled in the Breast and/or Cervical Cancer Program? Then you can't have other insurance, including Medicare, **if** the insurance covers treatment for breast and/or cervical cancer.

TennCare Standard is the second kind of TennCare. Only certain people qualify for TennCare Standard. TennCare Standard is for children under age 19 who are losing their TennCare Medicaid.[1] When it was time to see if they could keep TennCare Medicaid, they weren't eligible. But, the TennCare Standard rules say that these children can move to TennCare Standard if they don't have access to group health insurance. Sometimes they must have a health condition, too.

Having access to other insurance, even Medicare, is not allowed for children who have TennCare Standard.

There is another kind of TennCare Standard, for adults age 21 and older, called TennCare Standard Spend Down (SSD). It's called "Spend Down" because, to qualify, you use medical bills to "spend down" (or lower) your income. Adults can only apply during certain times of the year and must meet other rules too. It's ok to have SSD and other insurance, like Medicare, as long as you meet the rules.

Why is it important to know the kind of TennCare you have? Because it helps you know about the kind of TennCare benefits you have. It also helps you know if you must pay co-pays for TennCare services. We'll tell you more about your TennCare benefits and co-pays later in this handbook.

TennCare sent you a letter to tell you that you have TennCare and what day your TennCare started. If you have questions or problems about your TennCare dates, you can call the Tennessee Health Connection for free at **1-855-259-0701**.

[1] Eligibility categories for CHOICES and Employment and Community First CHOICES are technically "TennCare Standard" categories. However, Member ID cards, etc. will identify individuals enrolled in these categories as being in TennCare Medicaid. So, for purposes of this handbook, they are considered TennCare Medicaid.

Important! State law says you must tell TennCare about any changes that may affect your coverage. You **must** report these changes within 10 days of the change. And, you must give TennCare the proof they need to make the change. Call the Tennessee Health Connection right away if:

- You move.**
- You change jobs.
- The number of people in your family changes.
- Your income changes.
- You get or can get group health insurance.

Anytime you move, you must tell TennCare about your new address. **Why? TennCare sends you important information about your TennCare coverage and benefits in the mail. If they don't have your current address, you **could lose** your TennCare. Call the Tennessee Health Connection at **1-855-259-0701** to tell TennCare about your new address.

Do you get SSI checks from the Social Security Administration (SSA)? Then you must call your local SSA office and give them your new address.

After you call the Tennessee Health Connection **or** Social Security, call us at **1-800-600-4441** and tell us your new address too.

Your TennCare Health Plans

Amerigroup is your TennCare health plan that helps you get **physical or behavioral health care (mental health, alcohol and drug abuse services).** If you're in CHOICES or Employment and Community First CHOICES, we help you get long-term care too. You can read more about long-term care in Part 3 of this handbook. We're sometimes called your Managed Care Organization, or MCO. For questions about getting physical or behavioral health care, call us at **1-800-600-4441**. It's a free call. You can also call us for help with CHOICES or Employment and Community First CHOICES.

You can call us Monday through Friday, 8 a.m. to 5 p.m. Central time, except for holidays. If you call after 5 p.m., you can leave a voice mail message. You don't have to redial. Wait for the prompt to tell you how to leave a message. A Member Services representative will call you back the next business day.

If it's after 5 p.m. when you call and you are sick, have a question about your health or want to speak to a nurse, you'll hear a prompt for the 24-hour Nurse HelpLine. You can get in touch with a nurse 24 hours a day, 7 days a week, 365 days a year.

When you're sick, you can also call **24-hour Nurse HelpLine**, our 24-hour nurse triage service. Call 1-866-864-2544. A registered nurse can help you:

- Find a doctor after hours or on weekends
- Get to an urgent care center or a walk-in clinic
- Schedule an appointment with your doctor or another doctor in our network

Do you have questions about your health? Do you need to know what kind of doctor you should see? Call our 24-hour Nurse HelpLine at **1-866-864-2544.** It's a free call.

Do you need to change your health plan?

Is Amerigroup the health plan that you asked for? If you need or want to change your health plan, you have 45 days from the day you got your TennCare letter. To change your health plan in the first 45 days, call the TennCare Solutions Unit at **1-800-878-3192** for free. Tell them you just got your TennCare and you want to change your health plan.

After 45 days, it's harder to change your health plan. Part 5 of this handbook tells you more about changing your health plan after your first 45 days.

- Do you want to change health plans because you're having problems getting health care or can't find a doctor? Call us at **1-800-600-4441** for free. We'll help you fix the problem. You don't have to change health plans to get the care you need.
- Do you want to change health plans so you can see a doctor that takes a different health plan? First, be sure that **all** of your doctors will take your new health plan. You'll only be able to see doctors that take your new plan.
- What if you want to change your health plan but you have an OK from us for care you haven't gotten yet? If you change your health plan and still need the care, you'll have to get a new OK from your new plan.

Pharmacy Health Plan

If you have prescription coverage through TennCare, your prescription benefits will be provided by a Pharmacy Benefits Manager, or PBM.

TennCare's pharmacy plan is called **Magellan Health Services.** Watch your mail for your new pharmacy card. What if you don't get your new pharmacy card soon? If you need a prescription filled, you can go to the pharmacy anyway. Tell them you have TennCare.

Before you go, make sure the pharmacy you use accepts TennCare. To find out, go to **http://www.tn.gov/tenncare/topic/member-pharmacy.** Near the top of the page, click the link to find a pharmacy. Then, under the **Enrollee** tab, click on **Find a Pharmacy or Physician.** Click **Pharmacy.** Enter the information requested to find pharmacies near you that accept TennCare. Or, you can call the TennCare pharmacy help desk at **1-888-816-1680**.

Do you need more help? Do you have questions about your card? Call TennCare's pharmacy help desk at **1-888-816-1680**.

Learn more about your prescription coverage in Parts 1 and 2 of this handbook.

Dental Health Plan for children

TennCare only covers dental care for children under the age of 21. TennCare's dental health plan is **DentaQuest.** They can help you if you have questions about dental care. To find a DentaQuest dentist, go to **http://www.dentaquest.com/state-plans/regions/tennessee/.** Then click **Find a Dentist.** Or you can call them at **1-855-418-1622**.

Note! TennCare does **not** cover any dental care, including oral surgery, for adults age 21 and older. However, if you are in Employment and Community First CHOICES, dental benefits are a covered service for you. You can learn more about this in Part 3 of this handbook.

Learn more about dental coverage for children under age 21 in Parts 1 and 2 of this handbook.

Part 1: Using your TennCare health plan

Every Amerigroup member has a Member card. This is what your card looks like:

Amerigroup
An Anthem Company
www.myamerigroup.com/TN

Effective Date:
Date of Birth:
ID Number:
Benefit Indicator:

AMERIGROUP COMMUNITY CARE
TennCare Medicaid

Member Name:
TennCare Number:
Primary Care Provider (PCP):
PCP Telephone #:
Vision: **1-800-428-8789**
Dental: **1-855-418-1622**
Pharmacy: **1-888-816-1680**
Amerigroup Member Services/Nurse HelpLine
and Behavioral Health:

MEMBERS: Please carry this card at all times. Show this card before you get medical care. You do not need to show this card before you get emergency care. If you have an emergency, call 911 or go to the nearest emergency room. Always call your Amerigroup PCP for nonemergency care. If you have questions, call Member Services at . If you are deaf or hard of hearing, please call 711.
MIEMBROS: Favor de llevar esta tarjeta con usted en todo momento. Presente esta tarjeta antes de recibir atención médica. No tiene que presentarla para recibir atención de emergencia. Si tiene una emergencia, llame al 911 ó vaya a la sala de emergencia más cercana. Llame siempre a su PCP de Amerigroup para atención que no sea de emergencia. Si tiene preguntas, llame a Servicios para Miembros al . Si es sordo o tiene problemas de audicón, favor de llamar al 711.
HOSPITALS: Preadmission certification is required for all nonemergency admissions including outpatient surgery. For emergency admissions, notify Amerigroup within one business day after treatment at .
PROVIDERS: Certain services must be precertified. Care that is not precertified may not be covered. For precertification/billing information, call .

SUBMIT CLAIMS TO:
AMERIGROUP • P.O. BOX 61010 • VIRGINIA BEACH, VA 23466-1010
USE OF THIS CARD BY ANY PERSON OTHER THAN THE MEMBER IS FRAUD.
EL USO DE ESTA TARJETA POR CUALQUIER PERSONA QUE NO SEA EL MIEMBRO SE CONSIDERA FRAUDE.

TN01 7/15

Here are some of the things that your card has on it:

- **Member Name** is the name of the person who can use this card.
- **ID Number** is the number that tells us who you are.
- **TennCare Number** tells us what part of Tennessee you live in.
- **Primary Care Provider (PCP)** is the person you see for your health care.
- **Effective Date** is the date that you can start seeing your PCP listed on your card.
- **Date of Birth** is your birth date.

- **Co-pays** are what you pay for each health care service. Not everyone has co-pays.
- **Benefit Indicator** is the kind of TennCare benefit package you have. Your benefit package is the kind of services or care TennCare covers for you.

Carry your card with you all of the time. You’ll need to show it when you go to see your doctor and when you go to the hospital.

This card is only for you. Don’t let anyone else use your card. If your card is lost or stolen, or if it has wrong information on it, call us at **1-800-600-4441** for a new card. It’s a free call.

If you have questions about TennCare or Amerigroup, you can:

Call us at **1-800-600-4441** or

Write to us at: **Amerigroup Community Care**
22 Century Blvd., Suite 220
Nashville, TN 37214

Amerigroup Providers – In Network

The doctors and other people and places who work with Amerigroup are called the **Provider Network.** This includes providers in CHOICES and Employment and Community First CHOICES. All of these providers are listed in our **Provider Directory.** There are special directories for Providers in CHOICES and Employment and Community First CHOICES. You can find each of these Provider Directories online at www.myamerigroup.com/TN. Or call us at **1-800-600-4441** to get a list. Providers may have signed up or dropped out after the list was printed. But, the online Provider Directory is updated every week. You can also call us at **1-800-600-4441** to find out of a provider is in our network.

Sometimes your provider can't give you the care or treatment you need because of ethical (moral) or religious reasons. Call us at **1-800-600-4441**. We can help you find a provider who can give you the care or treatment you need.

To find doctors who speak other languages, you can also check the Amerigroup Provider Directory.

For a current list of primary care providers and specialists, visit www.myamerigroup.com/TN and click on **Find a doctor**. You can also look at or download a PDF version of the directory. This has a section for foreign languages spoken at primary care provider and specialist offices. When you visit www.myamerigroup.com/TN, you can enter your member ID number and download the Amerigroup mobile app for smartphones. This app will let you look up providers right from your phone.

You **must** go to doctors and other providers who take Amerigroup so TennCare will pay for your health care.

But, if you also have Medicare, you **don't** have to use doctors who take Amerigroup. You can go to any doctor that takes Medicare. To find out more about how Medicare works with TennCare see Part 4 of this handbook.

Out of Network

A doctor or other provider who is not in the Provider Network and doesn't take Amerigroup is called an **Out-of-Network provider.** Most of the time if you go to a doctor or other provider who is Out-of-Network **TennCare will not pay.**

But, sometimes, like in emergencies or to see specialists, TennCare will pay for a doctor who is Out-of-Network. Unless it's an emergency, you must have an **OK** first. The sections **Specialists** and **Emergencies** tell you more about when you can go to someone who is Out-of-Network.

If you were already getting care or treatment when your TennCare started, you may be able to keep getting the care without an OK or referral. Call us at 1-800-600-4441 to find out how.

How to get free language help at your health care visits

If English is not your first language, you can ask for an interpreter when you go to get your care. This is a free service for you. **Before your appointment, call us or your provider** so you can get help with language services.

You can also check in our Provider Directory to find doctors who speak other languages.

How to get help with a ride to your health care visits

If you don't have a way to get to your health care visits, you may be able to get a ride from TennCare.

You can get help with a ride:
- **only** for services covered by TennCare, and
- **only** if you don't have any other way to get there.

You can have someone ride with you to your appointment if:
- you are a child under the age of 21 or
- you have a disability and need help to get the service (like someone to open doors for you, push your wheelchair, help you with reading or decision-making).

If you need a ride to your appointment or have questions about having someone ride with you, call Tennessee Carriers at 1-866-680-0633.

Try to call **at least 72 hours before** your health care appointment to make sure that you can get a ride. If you change times or cancel your health care appointment, you must change or cancel your ride too.

Doctor visits

Your Primary Care Provider – the main person you go to for your care

You will go to one main person for your health care. He or she can be a doctor, a nurse practitioner, or a physician's assistant. This person is called your **Primary Care Provider**, or **PCP.**

The name of your PCP is sometimes listed on the front of your card. What if your card does not list the name of your PCP? Call us at 1-800-600-4441 for the name of your PCP or find out about other PCPs in our network. What if you want to change your PCP? **The next page tells you how.**

Most PCPs have regular office hours. But, you can call your PCP anytime. If you call after regular office hours, they will tell you how to reach the doctor. If you can't talk to someone after hours, call us at **1-800-600-4441**.

If your PCP is new for you, you should get to know your PCP. Call to get an appointment with your PCP as soon as you can. This is even more important if you've been getting care or treatment from a different doctor. We want to make sure that you keep getting the care you need. But even if you feel OK, you should call to get a check-up with your PCP.

Before you go to your first appointment with your PCP:

1. Ask your past doctor to send your medical records to your PCP. This will not cost you anything. These records are yours. They will help your PCP learn about your health.
2. Call your PCP to schedule your appointment.
3. Have your Amerigroup card ready when you call.
4. Say you are an Amerigroup member and give them your ID number. Tell your PCP if you have any other insurance.
5. Write down your appointment date and time. If you're a new patient, the provider may ask you to come early. Write down the time they ask you to be there.
6. Make a list of questions you want to ask your PCP. List any health problems you have.
7. If you need a ride to the appointment and have no other way to get there, we can help you with a ride. Try to call at least 72 hours before your appointment. Part 5 tells you more about getting a ride.

On the day of your appointment:

1. Take all of your medicines and list of questions with you so your PCP will know how to help you.
2. Be on time for your visit. If you cannot keep your appointment, call your PCP to get a new time.
3. Take your Amerigroup ID card with you. Your PCP may make a copy of it. If you have any other insurance, take that ID card with you, too.
4. Pay your co-pay if you have one. You can find out more about co-pays in Part 4.

Your PCP will give you **most** of your health care. Your PCP can find and treat health problems early. He or she will have your medical records. Your PCP can see your whole health care picture. Your PCP keeps track of all of the care you get.

Changing your PCP (doctor)

There are many reasons why you may need to change your PCP. You may want to see a PCP whose office is closer to you. Or your PCP may stop working with us. If your PCP stops working with Amerigroup, we will send you a letter asking you to find a new PCP. If you do not find a new PCP, we will find one for you so that you can keep getting your care.

To change your PCP:

1. Find a new PCP in the Amerigroup network. To find a new PCP, look in our Provider Directory. Or you can go online at www.myamerigroup.com/TN, or call **1-800-600-4441**.

2. Then call the new PCP to make sure that he or she is in the Amerigroup provider network. **Be sure to ask** if he or she is taking new patients.

3. If the new PCP is in our network and taking new patients, fill out the **PCP Change Request** in Part 8 and mail it back to us. Or you can call us at **1-800-600-4441** to tell us the name of your new PCP.

Need help finding a new PCP? Call us at 1-800-600-4441. We'll work with you to find a new PCP who is taking new patients.

If you change your PCP:

- We will send you a new Amerigroup card. It will have the name of your new PCP on it. The effective date on your new card is when we will start paying for visits to your new PCP.
- Any care that was scheduled for you by your old PCP has to be OK'd again by your new PCP. So even if you got a referral to a specialist from your old PCP, you will have to get a new referral from your new PCP.
- What if you are changing PCPs because you changed health plans? You still have to get a new OK for your care from your new PCP.
- And if you are in the middle of a treatment plan, you should call your new PCP right away. Your new PCP needs to know about all of the care you have been getting. He or she can help you keep getting the care you need.

Behavioral Health (Mental health, alcohol or drug abuse services)

You do **not** need to see your PCP before getting Behavioral Health services. But, you will need to get your care from someone who is in our network. If you're getting care now, ask your provider if they take Amerigroup.

A Community Mental Health Agency (CMHA) is one place you can go for mental, alcohol or drug abuse services. Most CMHAs take TennCare.

Before your first visit:

1. **Ask** your past doctor to send your records to your new provider. They will help your provider learn about your needs.
2. **Have your Amerigroup card ready** when you call to schedule your appointment with your new provider.
3. Say you are an Amerigroup member and give your **ID number.** If you have any other insurance, tell them.
4. **Write down** your appointment date and time. If you are a new patient, the provider may ask you to come early. Write down the time they ask you to be there.
5. **Make a list** of questions you want to ask your provider. List any problems you have.
6. If you need a ride to the appointment and have no other way to get there, we can help you with a ride. Try to **call at least 72 hours** before your visit. Page 7 tells you more about getting a ride.

On the day of your appointment:

1. **Take** all of your medicines and list of questions with you so your provider will know how to help you.
2. **Be on time** for your visit. If you cannot keep your appointment, call your provider to get a new time.
3. **Take** your **Amerigroup ID card** with you. Your provider may make a copy of it. If you have any other insurance, take that ID card with you, too.
4. **Pay** your co-pay if you have one. You can find out more about co-pays in Part 4.

If you need help finding mental health, alcohol and drug abuse services, call us at **1-800-600-4441**. Or, if you have questions about mental health, alcohol and drug abuse services, call us at **1-800-600-4441**. It's a free call.

Specialist providers

A **specialist** is a doctor who gives care for a certain illness or part of the body. One kind of specialist is a cardiologist, who is a heart doctor. Another kind of specialist is an oncologist, who treats cancer. There are many kinds of specialists.

Your PCP may send you to a specialist for care. This is called a **referral**. If your PCP wants you to go to a specialist, he or she will set up the appointment with the specialist for you.

If the specialist is not in our Provider Network, your PCP must get an OK from us first. If you have co-pays, your co-pay is the same even if the specialist is Out-of-Network.

Important! You cannot go to a specialist without your PCP's referral. We will only pay for a specialist visit if your PCP sends you.

But, you **do not** have to see your PCP first to go to a women's health doctor for well-woman checkups or prenatal care. A women's health doctor is called an OB/GYN. The women's health specialist must still be in our network. More information about women's health care is in Part 2 of this handbook.

And remember, you **do not** have to see your PCP first to see a behavioral health provider for mental health, alcohol or substance abuse services.

Hospital care

If you need hospital care, your PCP or behavioral health provider will set it up for you.

You must have your PCP's OK to get hospital care.
Unless it is an emergency, we will only pay for hospital care if your PCP sends you.

Emergencies for physical health

Always carry your Amerigroup card with you. In case of an emergency, doctors will know you have TennCare. You can get emergency health care any time you need it.

Emergencies are times when there could be serious danger or damage to your health if you don't get medical care right away. See Part 9 of this handbook for a full definition of an emergency.

Emergencies might be things like:	These are usually not emergencies:
• Shortness of breath, not able to talk	• Sore throat
• A bad cut, broken bone, or a burn	• Cold or flu
• Bleeding that cannot be stopped	• Lower back pain
• Strong chest pain that does not go away	• Ear ache
• Strong stomach pain that doesn’t stop	• Stomach ache
• Seizures that cause someone to pass out	• Small, not deep, cuts
• Not able to move your legs or arms	• Bruise
• A person who will not wake up	• Headache, unless it is very bad and like you’ve never had before
• Drug overdose	• Arthritis

If you think you have an emergency, go to the nearest hospital Emergency Room (ER). In an emergency, you can go to a hospital that is not in the Provider Network. If you can’t get to the ER, call 911 or your local ambulance service.

If you are not sure if it’s an emergency, call your PCP. You can call your PCP anytime. Your PCP can help you get emergency care if you need it.

If you need emergency care, you don’t have to get an OK from anyone before you get emergency care.

After the ER treats you for the emergency, you will also get the care the doctor says you need to keep stable. This is called post-stabilization care.

After you get emergency care, you must tell your PCP. Your PCP needs to know about the emergency to help you with the follow-up care later. **You must call your PCP within 24 hours of getting emergency care.**

Mental Health Emergencies

You can get help for a behavioral health emergency anytime even if you are away from home.

And you don’t have to get an OK from anyone before you get emergency care.

If you have a behavioral health, alcohol or drug abuse emergency, go to the nearest mental health crisis walk in center **or** ER right away. What if you don’t know where your closest mental health crisis walk in center is? Call Mental Health Crisis Services at **1-855-CRISIS-1** (or **1-855-274-7471**) right away. These calls are free.

Or, you can call your provider. Your provider can help you get emergency care if you need it. TennCare pays for mental health emergencies even if the doctor or hospital isn’t in the Provider Network.

Emergencies are times when there could be serious danger or damage to your health **or** someone else's if you don't get help right away. See Part 9 of this handbook for a full definition of an emergency.

Emergencies might be things like:	These are usually not emergencies:
• Planning to hurt yourself	• Needing a prescription refill
• Thinking about hurting another person	• Asking for help to make an appointment

If you have this kind of emergency:
- Go to the nearest mental health crisis walk in center or ER right away or
- Call 911 or
- Call **Mental Health Crisis Services for Adults at 1-855-CRISIS-1** (or **1-855-274-7471**). These calls are free.

Children under age 18

If you are under 18 years old or your child is under age 18 and has a behavioral health (mental health, alcohol or drug abuse) emergency:
- Go to the nearest ER or
- Call 911 or
- Call Mental Health Crisis Services for Children and Youth at the following numbers:
  - Memphis Region at 1-866-791-9226
  - Rural West Tennessee at 1-866-791-9227
  - Rural Middle Tennessee at 1-866-791-9222
  - Nashville Region at 1-866-791-9221
  - Mental Health Co-op (Davidson County) at 1-865-539-2409
  - Knoxville Region – Helen Ross McNabb (Knox, Blount, Sevier, Loudon, and Monroe Counties) at 1-866-791-9224
  - Southeast Tennessee at 1-866-791-9225
  - Frontier Health (Hancock, Greene, Hawkins, Washington, Unicoi, Carter, and Johnson Counties) at 1-877-928-9062

Youth Villages, Frontier Health, Helen Ross McNabb, and Mental Health Co-Operative offer statewide crisis services for children under age 18. If you go to the ER, someone from one of these agencies in your area may come help evaluate your child's need for care.

If you have problems reaching someone at the number listed for your area, call **1-800-600-4441**. We will help you. You can also call 911. These calls are free.

Always carry your Amerigroup card with you. In case of an emergency, doctors will know that you have TennCare.

After the ER treats you for the emergency, you will also get the care that the doctor says you need to keep stable. This is called post-stabilization care.

After you get emergency care, you must tell your provider. Your provider needs to know about the emergency to help you with follow-up care later. **You must call your provider within 24 hours of getting emergency care.**

Emergency care away from home

Emergency care away from home works just like you were at home. **In an emergency**, you can go to a hospital that is Out-of-Network. Go to the nearest ER, or call 911. If you have a behavioral health emergency, you can call **Mental Health Crisis Services** for free at **1-855-CRISIS-1** (or **1-855-274-7471**). You must still call your PCP and health plan within 24 hours of getting the emergency care away from home.

Show your Amerigroup card when you get the emergency care. Ask the ER to send the bill to Amerigroup. If the ER says no, ask if they will send the bill to you at home. Or if you have to pay for the care, get a receipt.

When you get home, call us at **1-800-600-4441** and tell us you had to pay for your health care or that you have a bill for it. We will work with you and the provider to put in a claim for your care.

Important! TennCare and Amerigroup will only pay for emergencies away from home that are inside the United States. We can’t pay for care you get out of the country.

Part 2: Services that TennCare pays for

Benefit packages: covered services

Not everyone in TennCare has the same benefits. The benefits that are covered for you depend on the group you're in.

The card you received will have a Benefit Indicator on the front. It tells you what group you're in and the benefits that are covered for you based on your group. Your Benefit Indicator may be different than other members in your family. If your card does **not** have a Benefit Indicator on the front, you can find out what benefits you have from the charts below. Or, call us at **1-800-600-4441**.

Children under age 21

Go to pages 15 and 16 for the list of benefits groups A and H.

Benefit Indicator	Description of Group
A	• Child under age 21
H	• Child under age 21 who also has Medicare

Adults age 21 and older with TennCare Medicaid

Go to pages 17-19 for the list of benefits for groups B, E, J and L.

Benefit Indicator	Description of Group
B	• Over age 21
E	• Over age 21 and enrolled in a Home and Community Based Services (HCBS) waiver for persons with intellectual disabilities
J	• Over age 21 and is enrolled in TennCare CHOICES Group 1 or Group 2* and does not have Medicare
L	• Over age 21, enrolled in TennCare CHOICES Group 3* and does not have Medicare

*People enrolled in Employment and Community First CHOICES receive ECF CHOICES benefits in addition to the benefits listed in the charts. More information about TennCare CHOICES and Employment and Community First CHOICES can be found in **Part 3** of this handbook.

Adults age 21 and older with TennCare Medicaid and Medicare

Go to pages 19-22 for the list of benefits for groups F, G, K and M.

Benefit Indicator	Description of Group
F	• Over age 21 who also has Medicare
G	• Over age 21, enrolled in a Home and Community Based Services (HCBS) waiver for persons with intellectual disabilities, and has Medicare
K	• Over age 21, enrolled in TennCare CHOICES Group 1 or Group 2*, and has Medicare
M	• Over age 21, enrolled in TennCare CHOICES Group 3*, and has Medicare

*People enrolled in Employment and Community First CHOICES receive ECF CHOICES benefits in addition to the benefits listed in the charts. More information about TennCare CHOICES and Employment and Community First CHOICES can be found in **Part 3** of this handbook.

Adults age 21 and older with TennCare Standard

Go to pages 22 and 23 for the list of benefits for groups C and D.

Benefit Indicator	Description of Group
C	• Over age 21
D	• Over age 21 and is enrolled in Standard Spend Down

The groups of services are marked **A to M.** You can find a list of services for each group on the next pages. Some of the services have limits. This means that TennCare will pay for only a certain amount of that care. The services that are listed **as medically necessary** mean that you can have those services if your doctor, health plan, and TennCare all agree that you need them.

If you have questions about what your physical health or behavioral health care services are, call us at **1-800-600-4441**. Or call the Tennessee Health Connection at **1-855-259-0701**.

Benefits for Children under age 21

There are **2 different benefit packages for children** under age 21. Look at your child's TennCare card to find out which benefit package your child has.

All TennCare covered services must be medically necessary, as defined in the TennCare rules. The definition of medically necessary is in Part 9 of this handbook.

For more information on Covered Services and Exclusions, go to:
http://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-13.20161229.pdf

Benefit Packages A and H (Children under age 21)

TennCare Services	A	H
Behavioral health crisis services (mental health, alcohol and drug abuse services)	Covered	**Covered.** **This care is not covered by Medicare.**
Chiropractic services	Covered	**Covered, but Medicare is primary.**
CHOICES benefits (Nursing Facility care and certain Home and Community Based Services, HCBS)	Nursing Facility care is Covered **CHOICES HCBS is NOT covered**	**Nursing Facility care is covered but Medicare is primary for Skilled Nursing Facility services.** ***CHOICES HCBS is not covered***
Community health clinic services	Covered	**Covered, but Medicare is primary.**
Dental services	Covered	**Covered, but Medicare is primary.**
Durable medical equipment (DME)	Covered	**Covered, but Medicare is primary.**

TennCare Services	A	H
Early Periodic Screening Diagnosis and Treatment (EPSDT for children under age 21) (TennCare Medicaid)	Covered	**Covered, but Medicare is primary.**
Emergency air and ground ambulance	Covered	**Covered, but Medicare is primary.**
Home health services	Covered	**Covered, but Medicare is primary.**
Hospice care	Covered	**Covered, but Medicare is primary.**
Inpatient and outpatient substance abuse benefits	Covered	**Covered, but Medicare is primary.**
Inpatient hospital services	Covered	**Covered, but Medicare is primary.**
Lab and X-ray services	Covered	**Covered, but Medicare is primary.**
Medical supplies	Covered	**Covered, but Medicare is primary.**
Behavioral Health Intensive Community Based Treatment	Covered	**Covered.** **This care is not covered by Medicare.**
Non-emergency transportation	Covered	**Covered, but Medicare is primary.**
Nursing facility care (CHOICES)	Covered	**Nursing Facility care is covered but Medicare is primary for Skilled Nursing Facility services.**
Occupational therapy	Covered	**Covered, but Medicare is primary.**
Organ transplant and donor procurement	Covered	**Covered, but Medicare is primary.**
Outpatient hospital services	Covered	**Covered, but Medicare is primary.**
Outpatient behavioral health services (mental health, alcohol and drug abuse services)	Covered	**Covered, but Medicare is primary.**
Pharmacy services	Covered	**Covered, but Medicare is primary.**
Physical exams and checkups, diagnostic and treatment services (TennCare Standard)	Covered	**Covered, but Medicare is primary.**
Physical therapy services	Covered	**Covered, but Medicare is primary.**
Physician services	Covered	**Covered, but Medicare is primary.**
Private duty nursing	Covered	**Covered.** **This care is not covered by Medicare.**
Psychiatric inpatient facility services	Covered	**Covered, but Medicare is primary.**
Psychiatric rehabilitation services	Covered	**Covered.** **This care is not covered by Medicare.**
Psychiatric residential treatment services	Covered	**Covered, but Medicare is primary.**
Reconstructive breast surgery	Covered	**Covered, but Medicare is primary.**
Renal dialysis services	Covered	**Covered, but Medicare is primary.**
Speech therapy services	Covered	**Covered, but Medicare is primary.**
Vision services	**Covered**	**Covered, but Medicare is primary.**

Benefits for adults age 21 and older

There are **10 different benefit packages for adults** age 21 and older who have TennCare. Look at your TennCare card to find out which benefit package you have.

All TennCare covered services must be medically necessary, as defined in TennCare rules. The definition of medically necessary is in Part 9 of this handbook. For more information on Covered Services and Exclusions, go to: **http://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-13.20161229.pdf**

Benefit Packages B, E, J, and L (Adults age 21 and older with TennCare Medicaid)

TennCare Services	B	E	J	L
Behavioral health crisis services (mental health, alcohol and drug abuse services)	Covered	Covered	Covered	**Covered**
Chiropractic services	Not Covered	Not Covered	Not Covered	**Not Covered**
Community health clinic services	Covered	Covered	Covered	**Covered**
CHOICES benefits (Nursing Facility care and certain Home and Community Based Services, HCBS)	Not Covered	Not Covered	Covered. For more information, see CHOICES in Part 3.	**Covered, but limited to Group 3 HCBS only. Nursing Facility care not covered. For more information, see CHOICES in Part 3 of this handbook.**
Dental services	Not Covered	Not Covered	Covered, with limits, only for adults in Employment and Community First CHOICES.	Covered, with limits, only for adults in Employment and Community First CHOICES.
Durable medical equipment (DME)	Covered	Covered	Covered	**Covered**
Emergency air and ground ambulance	Covered	Covered	Covered	**Covered**
Home health services	Covered with limits. See “Care with limits” starting on page 24	Covered with limits. See “Care with limits” starting on page 24	Covered with limits. See “Care with limits” starting on page 24.	**Covered with limits. See “Care with limits” starting on page 24.**

TennCare Services	B	E	J	L
Hospice care	Covered	Covered	Covered	**Covered**
Inpatient and outpatient substance abuse services	Covered	Covered	Covered	**Covered**
Inpatient hospital services	Covered	Covered	Covered	**Covered**
Lab and x-ray services	Covered	Covered	Covered	**Covered**
Medical supplies	Covered	Covered	Covered	**Covered**
Behavioral Health Intensive Community Based Treatment	Covered	Covered	Covered	**Covered**
Non-emergency transportation	Covered	Covered	Covered	**Covered**
Occupational therapy	Covered	Covered	Covered	**Covered**
Organ transplant and donor procurement	Covered	Covered	Covered	**Covered**
Outpatient hospital services	Covered	Covered	Covered	**Covered**
Outpatient behavioral health services (mental health, alcohol and drug abuse services)	Covered	Covered	Covered	**Covered**
Pharmacy services	Covered with limits. See "Care with limits" starting on page 24.	Covered – no limit	Covered – no limit	**Covered with limits. See "Care with limits" starting on page 24.**
Physical therapy services	Covered	Covered	Covered	**Covered**
Physician services	Covered	Covered	Covered	**Covered**
Private duty nursing	Covered with limits.	Covered with limits.	Covered with limits. See "Care with limits" starting on page 24.	**Covered with limits. See "Care with limits" starting on page 24.**

TennCare Services	B	E	J	L
	See "Care with limits" starting on page 24.	See "Care with limits" starting on page 24.		
Psychiatric inpatient facility services	Covered	Covered	Covered	**Covered**
Psychiatric rehabilitation services	Covered	Covered	Covered	**Covered**
Psychiatric residential treatment services	Covered	Covered	Covered	**Covered**
Reconstructive breast surgery	Covered	Covered	Covered	**Covered**
Renal dialysis services	Covered	Covered	Covered	**Covered**
Speech therapy services	Covered	Covered	Covered	**Covered**
Vision services	**Covered with limits. See "Care with limits" starting on page 24.**	**Covered with limits. See "Care with limits" starting on page 24.**	**Covered with limits. See "Care with limits" starting on page 24.**	**Covered with limits. See "Care with limits" starting on page 24.**

Benefit Packages F, G, K and M (Adults with TennCare Medicaid and Medicare)

TennCare Services	F	G	K	M
Behavioral health crisis services (mental health, alcohol and drug abuse services)	Covered Medicare does not cover this care	Covered Medicare does not cover this care	Covered Medicare does not cover this care	**Covered Medicare does not cover this care**
Chiropractic services	Not Covered Medicare covers this benefit	Not Covered Medicare covers this benefit	Not Covered Medicare covers this benefit	**Not Covered Medicare covers this benefit**
Community health clinic services	Covered Medicare is primary	Covered Medicare is primary	Covered Medicare is primary	**Covered Medicare is primary**

TennCare Services	F	G	K	M
CHOICES benefits (Nursing Facility care and certain Home and Community Based Services, HCBS)	Not Covered	Not Covered	Covered. Medicare is primary for Skilled Nursing Facility care. For more information, see CHOICES in Part 3 of this handbook.	**Covered, but limited to Group 3 HCBS only. Nursing Facility care not covered. Medicare covers Skilled Nursing Facility care. For more information, see CHOICES in Part 3 of this handbook.**
Dental services	Not Covered Medicare covers limited dental benefits	Not Covered Medicare covers limited dental benefits	Covered, with limits, **only** for adults in Employment and Community First CHOICES. Medicare covers limited dental benefits	**Covered, with limits only for adults in Employment and Community First CHOICES. Medicare covers limited dental benefits**
Durable medical equipment (DME)	Covered Medicare is primary	Covered Medicare is primary	Covered Medicare is primary	**Covered Medicare is primary**
Emergency air and ground ambulance	Covered Medicare is primary	Covered Medicare is primary	Covered Medicare is primary	**Covered Medicare is primary**
Home health services	Covered with limits. Medicare is primary. See "Care with limits" starting on page 24.	Covered with limits. Medicare is primary. See "Care with limits" starting on page 24.	Covered with limits. Medicare is primary. See "Care with limits" starting on page 24.	**Covered with limits. Medicare is primary. See "Care with limits" starting on page 24.**
Hospice care	Covered Medicare is primary	Covered Medicare is primary	Covered Medicare is primary	**Covered Medicare is primary**
Inpatient and outpatient substance abuse services	Covered Medicare is primary	Covered Medicare is primary	Covered Medicare is primary	**Covered Medicare is primary**
Inpatient hospital services	Covered Medicare is primary	Covered Medicare is primary	Covered Medicare is primary	**Covered Medicare is primary**

TennCare Services	F	G	K	M
Lab and x-ray services	Covered Medicare is primary	Covered Medicare is primary	Covered Medicare is primary	**Covered Medicare is primary**
Medical supplies	Covered Medicare is primary	Covered Medicare is primary	Covered Medicare is primary	**Covered Medicare is primary**
Behavioral Health Intensive Community Based Treatment	Covered Medicare does not cover this care	Covered Medicare does not cover this care	Covered Medicare does not cover this care	**Covered Medicare does not cover this care**
Non-emergency transportation	Covered Medicare is primary	Covered Medicare is primary	Covered Medicare is primary	**Covered Medicare is primary**
Occupational therapy	Covered Medicare is primary	Covered Medicare is primary	Covered Medicare is primary	**Covered Medicare is primary**
Organ transplant and donor procurement	Covered Medicare is primary	Covered Medicare is primary	Covered Medicare is primary	**Covered Medicare is primary**
Outpatient hospital services	Covered Medicare is primary	Covered Medicare is primary	Covered Medicare is primary	**Covered Medicare is primary**
Outpatient behavioral health services (mental health, alcohol and drug abuse services)	Covered Medicare is primary	Covered Medicare is primary	Covered Medicare is primary	**Covered Medicare is primary**
Pharmacy services	Not Covered. Available through Medicare Part D	Not Covered. Available through Medicare Part D	Not Covered. Available through Medicare Part D	**Not Covered. Available through Medicare Part D**
Physical therapy services	Covered Medicare is primary	Covered Medicare is primary	Covered Medicare is primary	**Covered Medicare is primary**
Physician services	Covered Medicare is primary	Covered Medicare is primary	Covered Medicare is primary	**Covered Medicare is primary**
Private duty nursing	Covered with limits. Medicare does not cover this care; See "Care with	Covered with limits. Medicare does not cover this care; See "Care with	Covered with limits. Medicare does not cover this care; See "Care with limits" starting on page 24.	**Covered with limits Medicare does not cover this care; See "Care with limits"**

TennCare Services	F	G	K	M
	limits" starting on page 24.	limits" starting on page 24.		**starting on page 24.**
Psychiatric inpatient facility services	Covered Medicare is primary	Covered Medicare is primary	Covered Medicare is primary	**Covered Medicare is primary**
Psychiatric rehabilitation services	Covered Medicare does not cover this care	Covered Medicare does not cover this care	Covered Medicare does not cover this care	**Covered Medicare does not cover this care**
Psychiatric residential treatment services	Covered Medicare is primary	Covered Medicare is primary	Covered Medicare is primary	**Covered Medicare is primary**
Reconstructive breast surgery	Covered Medicare is primary	Covered Medicare is primary	Covered Medicare is primary	**Covered Medicare is primary**
Renal dialysis services	Covered Medicare is primary	Covered Medicare is primary	Covered Medicare is primary	**Covered Medicare is primary**
Speech therapy services	Covered Medicare is primary	Covered Medicare is primary	Covered Medicare is primary	**Covered Medicare is primary**
Vision services	**Covered with limits. Medicare is primary; See "Care with limits" starting on page 24.**	**Covered with limits. Medicare is primary; See "Care with limits" starting on page 24.**	**Covered with limits. Medicare is primary; See "Care with limits" starting on page 24.**	**Covered with limits. Medicare is primary; See "Care with limits" starting on page 24.**

Benefit Packages C and D (Adults age 21 and older with TennCare Standard)[2]

TennCare Services	C	D
Behavioral health crisis services (mental health, alcohol and drug abuse services)	Covered	**Covered**
Chiropractic services	Not Covered	**Not Covered**
Community health clinic services	Covered	**Covered**
CHOICES benefits (Nursing Facility care and certain Home and Community Based Services, HCBS)	Not Covered	**Not Covered**
Dental services	Not Covered	**Not Covered**
Durable medical equipment (DME)	Covered	**Covered**

[2] Eligibility categories for CHOICES and Employment and Community First CHOICES are technically "TennCare Standard" categories. However, Member ID cards, etc. will identify individuals enrolled in these categories as being in TennCare Medicaid. So, for purposes of this handbook, they are considered TennCare Medicaid. This table is not applicable for adults in CHOICES and Employment and Community First CHOICES.

TennCare Services	C	D
Emergency air and ground ambulance	Covered	**Covered**
Home health services	Covered with limits. See "Care with limits" starting on page 24.	**Covered with limits. See "Care with limits" starting on page 24.**
Hospice care	Covered	**Covered**
Inpatient and outpatient substance abuse services	Covered	**Covered**
Inpatient hospital services	Covered	**Covered**
Lab and x-ray services	Covered	**Covered**
Medical supplies	Covered	**Covered**
Behavioral Health Intensive Community Based Treatment	Covered	**Covered**
Non-emergency transportation	Covered	**Covered**
Occupational therapy	Covered	**Covered**
Organ transplant and donor procurement	Covered	**Covered**
Outpatient hospital services	Covered	**Covered**
Outpatient behavioral health services (mental health, alcohol and drug abuse services)	Covered	**Covered**
Pharmacy services	Not Covered	**Covered with limits. See "Care with limits" starting on page 24.**
Physical therapy services	Covered	**Covered**
Physician services	Covered	**Covered**
Private duty nursing	Covered with limits. See "Care with limits" starting on page 24.	**Covered with limits. See "Care with limits" starting on page 24.**
Psychiatric inpatient facility services	Covered	**Covered**
Psychiatric rehabilitation services	Covered	**Covered**
Psychiatric residential treatment services	Covered	**Covered**
Reconstructive breast surgery	Covered	**Covered**
Renal dialysis services	Covered	**Covered**
Speech therapy services	Covered	**Covered**
Vision services	**Covered with limits. See "Care with limits" starting on page 24.**	**Covered with limits. See "Care with limits" starting on page 24.**

Care with limits

Benefits for children under the age of 21 are covered as medically necessary. But some TennCare benefits work differently for adults age 21 and older. These kinds of care and medicine have limits for adults age 21 and older:

1. **Prescription Medicine**
2. **Trigger Point Injections**
3. **Medial Nerve Blocks used to diagnose the cause of back pain.**
4. **Epidural Injections**
5. **Urine Drug Screenings**
6. **Private Duty Nursing and Home Health Services**
7. **Vision Services**

1. Prescription medicine

Most, but not everyone on TennCare, has pharmacy benefits. If you also have Medicare, there's an important message for you in the box on page 75.

Children under age 21 who have pharmacy benefits through TennCare **do not** have a limit on the number of prescriptions TennCare will pay for each month. And some adults who get long-term care that TennCare pays for don't have a monthly limit on prescriptions either. This includes:

- People who get care in a nursing home,
- People who get care in a special nursing home for people with intellectual disabilities (called an intermediate care facility for individuals with intellectual disabilities, or ICF/IID), and
- People who qualify for care in a nursing home or ICF/IID but get home care instead.

However, **most** adults who have TennCare have a limit on how many prescriptions TennCare will pay for each month. TennCare Medicaid will only pay for **5** prescriptions or refills each month. And only **2 of the 5** prescriptions can be brand name medicines. That means that at least **3** must be generic. TennCare will start counting your prescriptions and refills on the first day of each month. This limit includes prescriptions for physical health care **and** mental health care or alcohol or drug abuse.

How do I know if TennCare covers my prescription medicines?

TennCare has a list of prescription medicines called a **Preferred Drug List**, or **PDL**. The PDL is a list of medicines that TennCare covers.

There are brand name medicines and generic medicines on the Preferred Drug List. Most TennCare adults have co-pays for prescriptions. You can find more about co-pays in Part 4.

You can get many of these medicines at your pharmacy with a prescription from your doctor. But, some of these medicines must have an OK from the TennCare Pharmacy Program before you can get them. This OK is called a **Prior Authorization**, or **PA.** Your doctor must ask for a PA for some of the medicines on the list. Sometimes your doctor can change your prescription to a medicine that doesn't need a PA. But if your doctor says you must have medicine that needs an OK, he or she must ask for a PA.

What if I need more than 5 prescriptions or refills each month?
There is a list of medicines that do not count against your limit. It is called the **Exempt List.**

It's called the **Exempt List** because the medicines are exempt from (they don't count) against your limit. (Drug stores call it the "Auto Exemption" list.) After you've gotten **5** prescriptions or **2** brand name prescriptions in 1 month, you can still get medicines on the **Exempt List.** The list may change. But, TennCare and your drug store will make sure that medicines on the most current list **don't** count against your limit.

Do you need to find out if medicine you take is on that list? **Ask** your doctor or drug store. To see the most current list, you can use the internet. Go to the TennCare website at **http://www.tn.gov/tenncare/topic/member-pharmacy.** Click on **"Exempt".** Or, call the Tennessee Health Connection at **1-855-259-0701**. Ask them to mail you a copy.

There's another list of medicines that can help you with your monthly limit. It's called the **Over the Limit List.** After you've reached your monthly limit (of 5 prescriptions or 2 brand name prescriptions), your doctor can get TennCare's **OK** to pay for prescriptions on this list. (Drug stores may call it the **"**Prescriber Attestation" list.)

To get an **Over the Limit OK**, all of these things must be true:

1. The medicine must be **on the Over the Limit list.**
2. And, your doctor must call your TennCare pharmacy plan to ask for an **Over the Limit OK.**
3. And, your **doctor must sign an OK page from your TennCare pharmacy plan and** fax it back within **3** business days (not counting weekends or holidays).

What if it's a medicine on the Over the Limit list that you only need one time? The page your doctor must sign says if you don't get this medicine, one of these things will probably happen in the next 90 days:

1. You will need to go into the hospital.
2. Or, you won't be able to live at home anymore. (You'll have to go to a nursing home.)
3. Or, you may die.

If your doctor faxes the signed page back to your pharmacy health plan, you'll get an OK to go over your limit for this medicine one time. If you need the medicine again, your doctor must get another **Over the Limit OK.**

What if it's a medicine on the Over the Limit list that you need to keep getting for a long time? The page your doctor must sign says you must get this medicine **and** all the other medicines TennCare pays for **each** month. It says that if you don't, one of these things will probably happen in the next 90 days:

1. You will need to go into the hospital.
2. Or, you won't be able to live at home anymore. (You'll have to go to a nursing home.)
3. Or, you may die.

If your doctor faxes the signed page back to your pharmacy health plan, you'll get an OK to over your limit for this medicine. That **Over the Limit OK** will last until your prescription runs out (but no more than 1 year).

Important: Remember, some medicines need TennCare's OK even **before** you go over your limit. That's a different kind of OK called a **P**rior **A**uthorization or **PA.** Medicines on the **Over the Limit** list may need a **PA** too. If so, you'll need **both** OKs to get a medicine on the **Over the Limit list**. Your doctor can help you get both OKs if you need them.

What if a medicine on the **Over the Limit list** needs a **PA** and you **don't** have one? Then, TennCare still **won't** pay for the medicine. If your doctor asks for a **PA** and we turn you down, we'll send you a letter that says why. It will say how to appeal if you think we made a mistake. The **Over the Limit list** may change. To find out if a medicine is on the list, talk to your doctor or drug store.

If you want to see the most current list, you can use the internet. Go to the TennCare website at **http://www.tn.gov/tenncare/topic/member-pharmacy.** Click on **"Over the Limit."** Or, call the Tennessee Health Connection at **1-855-259-0701**. Ask them to mail you a copy.

Helpful Tips:

- If the medicine you're taking is more than your limit, ask your doctor if you **need** all the medicine you're taking. If you do, ask your drug store to help you pick the medicines that cost the most. Each month, get those filled first so TennCare will pay for them.
- Ask your doctor or drug store to find out if your medicine is on the Exempt List.
- Ask your doctor to prescribe medicines that are on the PDL.
- Ask your doctor to prescribe generic medicines whenever he or she can.
- Ask your doctor if your prescription needs a PA before you go to the pharmacy.

If you have questions about your **TennCare prescription coverage,** call TennCare's pharmacy help desk at **1-888-816-1680**. It's a free call.

If you have questions about your prescription medicines, call your doctor first. If you have problems getting your prescription medicines, see Part 5 of this handbook.

Important if you have Medicare:

Are you an adult age 21 or older and have Medicare?
You get your prescription medicine from Medicare Part D, not from TennCare's Pharmacy Program.

Are you a child under age 21 and have Medicare?
You get **most** of your prescription medicine from Medicare Part D. TennCare **does not** pay the co-pay for the medicines Medicare Part D covers. TennCare will **only** pay for your prescription medicines if:

- It's a kind of medicine that TennCare covers.
- And, it's a kind of medicine that Medicare doesn't cover.

Part 4 of this handbook tells you more about how TennCare works with Medicare.

2. Trigger point injections (shots)

The medicine is given with a needle in muscles that are "knotted" or very tense. TennCare will only pay for **4 trigger point injections in each muscle group every 6 months** for adults age 21 and older. A muscle group means the muscles in a certain area of your body, like the muscles that make up your upper arm or your back. We'll count each time you get a shot in one muscle group for 6 months in a row.

What if you get trigger point shots in 2 muscle groups, like in your upper arm and in your back? We'll count them separately. We'll count up to 4 shots in your arm **and** up to 4 shots in your back during one 6 month period of time.

3. Medial nerve blocks used to diagnose (figure out) the cause of back pain

Numbing medicine is given with a needle near nerves that are on each side of your spine. TennCare will only pay for **4 medial nerve blocks each year** given to diagnose the reason for your back pain. We'll start counting on January 1 and stop counting on December 31. Each year we'll pay for up to 4 diagnostic medial nerve blocks.

4. Epidural injections (shots)

The medicine is given with a needle around the spine. TennCare will only pay for **3 epidural shots every 6 months** for adults age 21 and older.

We'll count each one you get for 6 months in a row. **But,** TennCare will still pay for epidural shots women need during childbirth.

5. Urine Drug Screenings

These are drug tests that look for proof of illegal or controlled substances in your urine. Controlled substances are prescriptions that can be abused, like Lortab® and OxyContin®. TennCare will only pay for **12 urine drug screenings per year** for adults age 21 and older.

Starting October 1, TennCare will pay for 2 specific urine drug tests for each drug per year. Remember, urine drug tests look for proof of illegal or controlled substances in your urine. Controlled substances are prescriptions that can be abused, like Lortab® and Kadian® (morphine).

Right now, TennCare pays for 12 urine drug tests per year. TennCare also pays for 4 confirmation urine drug tests per year. "Confirmation" means if your test is "positive" for illegal or controlled substances, TennCare will pay to recheck the result 4 times per year. **TennCare will keep paying for 12 urine drug tests and 4 confirmation urine drug tests per year.**

But sometimes your provider may need a urine drug test to find out what kind of drug(s) you're taking. Or for prescriptions, your provider may need a urine drug test to be sure you're getting the right amount. When your provider asks for this kind of test, it's called a specific urine drug test. **Starting October 1, TennCare will only pay for 2 specific urine drug tests for each drug per year.**

For example, your provider can ask TennCare to pay to test your urine for Lortab® 2 times per year. Your provider can also ask TennCare to pay to test your urine for Kadian® (morphine) 2 times in that same year.

We'll start counting this new urine drug screening limit on October 1 and stop counting on December 31. Then on January 1, 2016, we'll start counting again. And we'll keep counting 12 urine drug tests and 4 confirmation urine drug tests per year.

6. Private Duty Nursing and Home Health Services

Private duty nursing and home health services are covered as medically necessary for children under the age of 21. But, these services work differently for adults age 21 or older.

Private duty nursing is nursing services only for people who require 8 hours or more of continuous nursing from a licensed nurse in a 24-hour period. A person who needs only intermittent skilled services does not qualify for private duty nursing.

TennCare will **not** cover private duty nursing or (PDN) services for adults age 21 or older **unless:**

- You are ventilator dependent for at least 12 hours each day.
- **Or**, you have a functioning tracheotomy **and** need certain other kinds of nursing care too.

For your safety, to get private duty nursing, you must have a relative or other person who can:

- Care for you when the private duty nurse is not with you
- And take care of your other non-nursing needs.

If you qualify for PDN, **your nurse will only be able to go with you to doctor's appointments, school and work.** Even though your nurse may go with you to these places, your nurse cannot drive you there. TennCare rules say your nurse **can't** drive you anywhere.

What if you need care at home but don't qualify for private duty nursing? You may still be able to get care at home. This care is called Home Health Care.

Home Health Care
There are 2 kinds of Home Health Care: Home Health Nursing and Home Health Aide Care. There are limits on the amount of Home Health Nurse and Home Health Aide Care you can get.

Part-time and intermittent Home Health Nursing Care
A home health nurse is someone who can visit you at home to provide medical care.
TennCare will **only** pay for:

- Up to 1 nurse visit each day
- Each visit must be less than 8 hours long
- And, no more than 27 hours of nursing care each week (30 hours each week if you qualify for care in a skilled nursing home)

Home Health Aide Care
A home health aide is someone to help you with certain things you can't do alone (like eat or take a bath).
TennCare will **only** pay for:

- Up to 2 home health aide visits each day
- No more than 8 hours of home health aide care each day
- And, no more than 35 hours a week of home health care (40 hours each week if you qualify for care in a skilled nursing home)

What if you need <u>both</u> Home Health Nursing and Aide care?
TennCare will **only** pay for:

- Up to 1 nurse visit per day
- Up to 2 home health aide visits per day
- No more than 8 hours of nursing and home health aide care **combined** each day
- No more than 27 hours of nursing care each week (30 hours per week if you qualify for care in a skilled nursing home)
- No more than 35 hours of nursing and home health aide care combined each week (40 hours per week if you qualify for care in a skilled nursing home)

TennCare will **only** pay for nursing services if you need care that can only be given by a nurse (care that can't be given by an aide). This is care like tube feeding or changing bandages. TennCare **won't** pay for a nurse if the only reason you need a nurse is because you **might** need to take medicine. The nurse will **only** stay with you as long as you need **nursing** care.

7. Vision Services
For adults age 21 and older, vision services are limited to medical evaluation and management of abnormal conditions and disorders of the eye. The first pair of cataract glasses or contact lens/lenses after cataract surgery are covered.

Other TennCare services

TennCare CHOICES in Long-Term Services and Supports Program
TennCare CHOICES in Long-Term Services and Supports (or CHOICES for short) is for adults (age 21 and older) with a physical disability and seniors (age 65 and older). CHOICES offers services to help a person live in their own home or in the community. These services are called **H**ome and **C**ommunity **B**ased **S**ervices or HCBS. These services can be provided in the home, on the job, or in the community to assist with daily living activities and allow people to work and be actively involved in their local community. CHOICES also provides care in a nursing home if it is needed. More information about CHOICES is found in Part 3 of this handbook.

Employment and Community First CHOICES
Employment and Community First CHOICES is for people of all ages who have an intellectual or developmental disability (I/DD). This includes people who have significant disabilities.

Services help people with I/DD gain as much independence as possible. People are supported to live with their family or in the community, not in an institution. Residential services are available for adults with I/DD who do not live with family but need supports where they live.

Employment and Community First CHOICES can help the person with I/DD explore the possibility of working. Services can also help people learn skills for work, find a job, and keep a job. This could be a part-time job, a full-time job or self-employment. Working helps people earn money, learn new skills, meet new people, and play an important role in their communities. Work can also help people stay healthy and build self-confidence.

Other services help people learn and do things at home and in the community that help people achieve their goals. If a person lives at home with their family, the services help the family support the person to become as independent as possible. Services also help people get actively involved in their communities and include peer supports for the person and for their family.

More information about Employment and Community First CHOICES is found in Part 3 of this handbook.

Special Services - Some services are covered by TennCare **only in special cases**. These are services like Population Health, Hospice Care, Sterilization, Abortion, and Hysterectomy. More about these services can be found below.

Population Health services provide you with information on how to stay healthy. If you have an ongoing illness or an unhealthy behavior, Population Health services can help you do things like:

- Understand your illness and how to feel better
- Quit smoking
- Manage your weight
- Have a healthy Pregnancy and healthy baby.

Population Health services are provided whether you are well, have an ongoing health problem or have a terrible health episode. Population Health services are available to you depending on your health risks and need for the service.

Population Health can provide you with a care manager. A care manager can help you get all the care you need. You may be able to have a care manager if you:

- Go to the ER a lot, or if you have to go into the hospital a lot, or
- Need health care before or after you have a transplant, or
- Have a lot of different doctors for different health problems or
- Have an ongoing illness that you don’t know how to deal with.

To see if you can have a care manager, or if you want to participate in the Population Health services, you (or someone on your behalf) can call **Amerigroup Population Health at 1-800-600-4441.**

Hospice Care is a kind of medical care for people who are terminally ill. You must use a hospice provider in our network. For help with hospice care, call us at **1-800-600-4441**.

Sterilization is the medical treatment or surgery that makes you not able to have children.
To have this treatment, you must:

- Be an adult age 21 or older.
- Be mentally stable and able to make decisions about your health.
- Not be in a mental institution or in prison.

- Fill out a paper that gives your OK. This is called a Sterilization Consent Form. You can call us at **1-800-600-4441** to get this paper.

You have to fill the paper out at least 30 days before you have the treatment. But in an emergency like premature delivery or abdominal surgery, you can fill the paper out at least 72 hours before you have the treatment.

Abortion is the medical treatment that ends a pregnancy. TennCare pays for this treatment only if:

- You are pregnant because of rape or incest, or
- You have a physical problem, injury, or illness that you could die from without an abortion.

Your doctor must fill out a paper called Certification of Medical Necessity for Abortion.

Hysterectomy is medical surgery that removes reproductive organs. A hysterectomy can be covered when you must have it to fix other medical problems. After a hysterectomy, you will not be able to have children. But, TennCare **will not** pay for this treatment if you have it just so you won't have children. TennCare pays for this treatment **only if it is medically necessary**.

You have to be told in words and in writing that having a hysterectomy means you are not able to have children. You have to sign a paper called Statement of Receipt of Information concerning Hysterectomy.

Preventive Care – care that keeps you well

TennCare covers preventive care for adults and children. **Preventive care** helps to keep you well and catches health problems early so they can be treated.

Note! Even if you have co-pays for your health care, you will **not** have co-pays for preventive care.

Some preventive care services are:
- Checkups for adults and children
- Care for women expecting a baby
- Well baby care
- Shots and tests
- Birth control information

Preventive care for adults

You can do some things for yourself to stay healthy:
- Stay active
- Eat right
- Exercise
- Don't smoke
- Don't drink alcohol or take drugs
- Do self-examinations
- Take medicine just as your doctor says
- Get regular checkups

You can go to your PCP for a check up to help you stay healthy. Your PCP may want to do tests to make sure you are OK. Some of these tests are for:
- Cholesterol
- Blood sugar
- Colon and rectal cancer
- Bone hardness (osteoporosis)
- Thyroid
- STDs (sexually transmitted diseases)
- HIV and AIDS
- Heart problems (EKG tests)
- TB (tuberculosis)
- Well-woman checkups (pap smears and mammogram)

You can get shots at your checkup too. These shots are called **vaccinations.** Some of these shots may be for:
- Tetanus
- Hepatitis B
- Pneumonia
- Flu
- Measles
- Mumps

Tennessee Health Link

TennCare members with behavioral health needs face many problems in getting the care they need within the health care system. Tennessee Health Link can help with this.

Tennessee Health Link is a team of professionals who work at a mental health clinic or behavioral health provider that can help these members with their health care. They provide whole-person, patient-centered, and coordinated care for assigned members with behavioral health conditions.

Members who are eligible for Health Link services are identified based on:

- their diagnosis,
- certain health care services they use, or
- functional need.

Health Link professionals will use care coordination and other services to help members with their behavioral and physical health. This includes:

- Comprehensive care management (e.g., creating care coordination and treatment plans)
- Care coordination (e.g., proactive outreach and follow up with primary care and behavioral health providers)
- Health promotion (e.g., educating the patient and his/her family on independent living skills)
- Transitional care (e.g., participating in the development of discharge plans)
- Patient and family support (e.g., supporting adherence to behavioral and physical health treatment)
- Referral to social supports (e.g., helping to find access to community supports including scheduling and follow through)

Women’s Health and Pregnancy

Well-woman checkups

TennCare covers some health care services that are special for women. These are “well-woman” checkups that help to keep you healthy. This kind of care is called **preventive care.** There are **no co-pays** for well-woman checkups.

Starting at age 21, all women should get **pap smears** on a regular basis**.** A pap smear is a screening test to check for cervical cancer and other problems.

Women should also have mammogram screenings as part of their well-woman checkup visits. A mammogram is an X-ray of the breast. It is used to check for breast cancer and other problems.

Sometimes if you have family members who have had cervical or breast cancer, your doctor may want you to start having pap smears and mammograms earlier or more often, to make sure you are OK.

Mammography screening benefits are available:

- for ages 35 to 40, at a minimum of one time
- for ages 40 to 50, every 2 years or more often if your doctor says you need it
- for ages 50 and older, every year

You can get well-woman checkups from your PCP, or from a specialist called an Obstetrician/Gynecologist. This kind of specialist is sometimes called an **OB/GYN doctor**.

You **do not** have to see your PCP first to go to an OB/GYN doctor. But, the OB/GYN doctor must still be in our Provider Directory so that TennCare will pay for the services.

Pregnancy

If you are pregnant, you should get health care **now**, so that you have a safer delivery. Health care while you are pregnant can help you to have a healthier baby. Care before your baby is born is called **prenatal care.** There are no co-pays for prenatal care.

You can get this kind of health care from your PCP, or from a specialist called an Obstetrician/Gynecologist. This kind of specialist is sometimes called an **OB/GYN doctor.**

You **do not** have to see your PCP first to go to an OB/GYN doctor. But, the OB/GYN doctor must still be in our Provider Directory so that TennCare will pay for the services.

If you are already more than **3 months** pregnant and you are already seeing an OB/GYN doctor when you get your TennCare, you can still see that doctor to get your care. But, he or she has to say OK to the amount that TennCare pays. Call us at **1-800-600-4441** to find out if you can still see this doctor. We may ask you to change to an OB/GYN doctor who is in our Provider Directory if it is safe to change.

Go to **all** of your OB/GYN visits, even if you feel fine. Your doctor will tell you how often to have checkups while you are pregnant. After your first visit, you may see your doctor every **4 weeks.** Then, after **7** months, you may see your doctor every **2 or 3 weeks**. When it gets close to when your baby is due, you may see your doctor every week.

Do what your doctor says to take good care of you and your baby. Remember to take the vitamins that your doctor tells you to. **Don't smoke or drink alcohol while you are pregnant.**

If your doctor prescribes medicine for you while you are pregnant, you **do not** have to pay a co-pay for it at the drug store. But, you have to tell the pharmacist that you are pregnant so he will not charge you a co-pay.

After your baby is born, you should have follow-up care for you and your baby. Care after your baby is born is called **postnatal care.** Postnatal care includes circumcisions done by a doctor and special screenings for newborns.

Both you and your baby need follow-up care. You should see your doctor **4 to 6** weeks after you have your baby. Your doctor will check to make sure you are OK.

You **must** find a PCP for your baby. It is a good idea to choose a PCP for your baby before he or she is born. The baby's doctor must be in our Provider Directory for TennCare to pay for health care services. Your baby should have a checkup by the PCP soon after birth. Call the doctor ahead of time to make the appointment for your baby's checkup. Well-baby checkups are part of **TennCare Kids**. Read more about **TennCare Kids** on the next pages.

TennCare will cover your baby when he or she is born.

Important! Tell the Tennessee Health Connection about your baby as soon as possible so you can make sure he or she gets on TennCare. Here's how to make sure your baby gets on TennCare:

- After your baby is born, the hospital will give you papers to get a Social Security number for your baby. **Fill out those papers and mail them to the Social Security office.**
- **Tell the Tennessee Health Connection about your baby as soon as you can.** Call them at **1-855-259-0701**. Tell them that you have filled out papers for the baby's Social Security number.
- When you get your baby's Social Security card in the mail, call the Tennessee Health Connection again. Give them your baby's Social Security number. If you **don't** tell them your baby's Social Security number, your baby may lose TennCare.

It is important to do these things before your baby is 1 month old, if possible.

Preventive care for children: TennCare Kids - Health care for your child or teen

Check In, Check Up, and Check Back!

TennCare Kids is the name for TennCare's program to keep children healthy. It used to be called TENNderCare. The federal name for the program is EPSDT, but in Tennessee, it's TennCare Kids. Your child and teen **need** regular health checkups, even if they seem healthy. These visits help your doctor **find and treat problems early**.

In TennCare Kids, checkups for children are **free** until they reach age 21. TennCare Kids also pays for all medically necessary care and medicine to treat problems found at the checkup. This includes medical, dental, speech, hearing, vision, and behavioral (mental health, alcohol or drug abuse problems).

If your child hasn't had a checkup lately, call your child's PCP today for an appointment. Ask for a TennCare Kids checkup. You can go to your child's PCP or the Health Department to get TennCare Kids checkups.

And, if someone else, like your child's teacher, is worried about your child's health, you can get a TennCare Kids checkup for your child.

TennCare Kids checkups may include:
- Health history
- Complete physical exam
- Laboratory tests (as needed)
- Immunizations (shots)
- Vision/hearing screening
- Developmental/behavioral screening (as needed)
- Advice on how to keep your child healthy

If your child's PCP (pediatrician) finds anything wrong, TennCare Kids also gives your child the medical, dental, speech, hearing, vision, and behavioral (mental health, alcohol or drug abuse) treatment that he or she needs.

Children should go to the doctor for checkups even if they are not sick. They should have TennCare Kids checkups when they are:

- at birth
- 3-5 days old
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- 3 years
- and then every year until age 21

The vaccination shots that children need to get, to keep from getting sick, are for:

- ✓ Diphtheria
- ✓ Tetanus
- ✓ Pertussis
- ✓ Polio
- ✓ Measles
- ✓ Mumps
- ✓ Rubella (MMR)
- ✓ HIB
- ✓ Flu (influenza)
- ✓ Hepatitis A and B
- ✓ Chicken pox (varicella)
- ✓ Pneumococcal
- ✓ Rotavirus
- ✓ Human papillomavirus (HPV)
- ✓ Meningitis

Look at the schedule of shots listed in Part 9 of this handbook. It is called **TennCare Kids**: Children and Teen Immunization Schedule. It will help you know when your child should get his or her shots.

Or, you can ask your child's PCP when your child should get his or her shots.

More about TennCare Kids can be found in Part 9 of this handbook.

Dental care for children (for teeth)

If you are a child under the age of 21, you also have a dental plan for your teeth called **DentaQuest.** Their phone number is **1-855-418-1622**. You can call DentaQuest to find a dentist. Or, if you have questions about caring for your child's teeth, you can call them. It's a free call.

Children's teeth need special care. Children under age 21 should have a checkup and cleaning every six months. Children need to start seeing a dentist by age 3 or even earlier for some children.

TennCare will pay for other dental care if it is medically necessary. Braces are covered **only** if they are medically necessary.

You do **not** need to see your PCP before you go to a dentist. But, you will need to go to a DentaQuest dentist.

This dental care is only for children under age 21. TennCare does not pay for any dental care for adults, unless you're in Employment and Community First CHOICES.

Vision care for children (for eyes)

Children's eyes also need special care. Children under 21 years old can have their eyes checked and get eyeglass lenses and frames as medically necessary. If the eyeglass lenses or frames are broken or lost, we will replace them as medically necessary. Your Amerigroup eye doctor will show you which frames you can choose from.

TennCare will pay for other vision care if it is medically necessary. Contacts are covered only if they are medically necessary.

Children do **not** have to see their PCP before seeing their Amerigroup eye doctor. But, the eye doctor must still be in our Provider Directory.

Non-covered services

Here is a general list of some services that are **not** covered for anyone by TennCare. You can find a **full** list of services that TennCare will not pay for, online in the TennCare rules at **http://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-13.20161229.pdf.**

Or, you can call us at 1-800-600-4441 for a full list.

Some Non-Covered Services are:

1. Services that are not medically necessary. But preventive care (care you need to stay well) **is** covered.
2. Services that are experimental or investigative.
3. Surgery for your appearance. But if you had a mastectomy, reconstructive breast surgery **is** covered.
4. Reversal of sterilization.
5. Artificial insemination, in-vitro fertilization or any other treatment to create a pregnancy.
6. Treatment of impotence.
7. Any medical or behavioral health (mental health, alcohol or drug abuse) treatment outside of the United States.
8. Autopsy or necropsy.
9. Physical exams that a new job says you need.
10. Any medical or behavioral health (mental health, alcohol or drug abuse) treatment if you are in local, state, or federal jail or prison.
11. Services that are covered by workers compensation insurance.
12. Services that you got before you had TennCare or after your TennCare ends.
13. Personal hygiene, luxury, or convenience items.
14. Convalescent Care and Sitter Services.
15. Services mainly for convalescent care or rest cures.
16. Foot care for comfort or appearance, like flat feet, corns, calluses, toenails.
17. Transsexual surgery and any treatment connected to it.
18. Radial keratotomy or other surgery to correct a refractive error of the eye.
19. Services given to you by someone in your family or any person that lives in your household except as permitted through consumer direction in the CHOICES and Employment and Community First CHOICES.
20. Medicines for:
    - hair growth
    - cosmetic purposes
    - controlling your appetite
    - treatment of impotence
    - treatment of infertility

21. Medicines that the FDA (Food and Drug Administration) says are:
    - DESI – this means that research says they are not effective
    - LTE – this means that research says they are less than effective IRS – this means that the medicines are identical, related, or similar to LTE medicines.

Some services are covered for children under age 21 but not for adults.
Services that are **not covered for adults** include:

1. Over-the-counter medicine (except prescribed prenatal vitamins)
2. Allergy medicines you get from the pharmacy even if you have a prescription
3. Medicine to treat acne and rosacea
4. Dental Services (except for people in Employment and Community First CHOICES)
5. Methadone clinic services
6. Eyeglasses, contact lens or eye exams for adults age 21 and older. But if you had cataract surgery, your first pair of cataract glasses or contact lens/lenses **is** covered.
7. Hearing aids or exams for your hearing for adults age 21 and older.

Part 3: TennCare Long-Term Services and Supports Programs

CHOICES

What is CHOICES?

TennCare CHOICES in Long-Term Services and Supports (or CHOICES for short) is for adults (age 21 and older) with a physical disability and seniors (age 65 and older). CHOICES offers services to help a person live in their own home or in the community. These services are called **H**ome and **C**ommunity **B**ased **S**ervices or HCBS. These services can be provided in the home, on the job, or in the community to assist with daily living activities and allow people to work and be actively involved in their local community. CHOICES also provides care in a nursing home if it is needed.

How do I apply for CHOICES?

If you think you need long-term services and supports, call us at **1-866-840-4991**. We may use a short screening that will be done over the phone to help decide if you may qualify for CHOICES. If the screening shows that you don't appear to qualify for CHOICES, you'll get a letter that says how you can finish applying for CHOICES.

If the screening shows that you might qualify for CHOICES, or if we don't conduct a screening over the phone, we will send a Care Coordinator to your home to do an assessment.

The purpose of the in-home assessment is to help you apply for CHOICES. It's also to find out:

- The kinds of help you need;
- The kinds of care being provided by family members and other caregivers to help meet your needs;
- And the gaps in care for which paid long-term services and supports may be needed.

If you want to receive care at home or in the community (instead of going to a nursing home), the assessment will help decide if your needs can be safely met in the home or community setting. And, for CHOICES Group 2 (you can read about all of the CHOICES Groups below), it will help decide if the cost of your care would exceed the cost of nursing home care.

This **doesn't** mean that you will receive services up to the cost of nursing home care. CHOICES won't pay for more services than you must have to safely meet your needs at home. And, CHOICES only pays for services to meet long-term services and supports needs that can't be met in other ways.

CHOICES services provided to you in your home or in the community will not take the place of care you get from family and friends or services you already receive. If you're getting help from community programs, receive services paid for by Medicare or other insurance, or have a family member that takes care of you, these services will not be replaced by paid care through CHOICES. Instead, the home care you receive through CHOICES will work together with the assistance you already receive to help you stay in your home and community longer. Care in CHOICES will be provided as cost-effectively as possible so that more people who need care will be able to get help.

However, if you have been getting services through the State-funded Options program, you won't qualify to get those services anymore. They are for people who don't get Medicaid. And if you've been getting services from programs funded by the Older Americans Act (like Meals on Wheels, homemaker, or the National Caregiver Family Support Programs) that you can now get through CHOICES, you'll get the care you need through CHOICES.

If you want home care, the Care Coordinator will also perform a risk assessment. This will help to identify any additional risks you may face as a result of choosing to receive care at home. It will also help to identify ways to help reduce those risks and to help keep you safe and healthy.

To see if you qualify to enroll in CHOICES, call us at **1-866-840-4991**.

Does someone you know that isn't on TennCare want to apply for CHOICES? They should contact their local Area Agency on Aging and Disability (AAAD) for free at **1-866-836-6678**. Their local AAAD will help them find out if they qualify for TennCare and CHOICES.

Who can enroll in CHOICES?

For now, there are three (3) groups of people who can qualify to enroll in CHOICES.

CHOICES Group 1 is for people of all ages who receive **nursing home care**.
To be in CHOICES Group 1, you must:
- Need the level of care provided in a nursing home;
- **And** qualify for Medicaid long-term services and supports;
- **And** receive nursing home services that TennCare pays for.

TennCare Long-Term Services and Supports will decide if you need the level of care provided in a nursing home. TennCare Member Services will decide if you qualify for Medicaid long-term services and supports. We'll help you fill out the papers TennCare needs to decide. What if TennCare says yes? If you're receiving nursing home services that TennCare will pay for, TennCare will enroll you into CHOICES Group 1. If TennCare says you don't qualify, you'll get a letter that says why. It will say how to appeal if you think it's a mistake.

CHOICES Group 2 is for certain people who **qualify for nursing home care**, but choose to **receive home care instead**. To be in CHOICES Group 2, you must:
- Need the level of care provided in a nursing home;
- **And** qualify for Medicaid long-term services and supports because you receive SSI payments OR because you need and **will receive** home care services instead of nursing home care.
- **And** be an adult 65 years of age or older;
- **Or** be an adult 21 years of age or older with a physical disability.

If you need home care services, but don't qualify in one of these groups, you can't be in CHOICES Group 2, but you may qualify for other kinds of long-term services and supports.

TennCare Long-Term Services and Supports will decide if you need the level of care provided in a nursing home. TennCare Member Services will decide if you qualify for Medicaid long-term services and supports for one of the reasons listed above. We'll help you fill out the papers they need to decide.

If TennCare says yes, to enroll in CHOICES Group 2 and begin receiving home care services:

- We must be able to safely meet your needs at home.
- And, the cost of your home care can't be more than the cost of nursing home care. The cost of your home care includes any home health or private duty nursing care you may need.

If we can't safely meet your needs at home, **or** if your care would cost more than nursing home care, you can't be in CHOICES Group 2. But, you may qualify for other kinds of long-term services and supports.

If TennCare says you don't qualify, you'll get a letter that says why. It will say how to appeal if you think it's a mistake.

CHOICES Group 3 is for certain people who **don't qualify for nursing home care**, but **need home care** to help them stay at home safely.

To be in CHOICES Group 3, you must:

- Be "at risk" of going into a nursing home unless you receive home care;
- **And** qualify for Medicaid long-term services and supports because you receive SSI payments OR because you need and **will receive** home care services to keep you from going into a nursing home.
- **And** be an adult 65 years of age or older;
- **Or** be an adult 21 years of age or older with a physical disability.

TennCare Long-Term Services and Supports will decide if you are "at risk" of going into a nursing home. TennCare Member Services will decide if you qualify for Medicaid long-term services and supports for one of the reasons listed above. We'll help you fill out the papers they need to decide.

If TennCare says yes, to enroll in CHOICES Group 3 and begin receiving home care services:

- We must be able to safely meet your needs at home with the care you'd get in CHOICES Group 3

If we can't safely meet your needs with the care you'd get in CHOICES Group 3, you can't be in CHOICES Group 3. But, TennCare may decide that you qualify for other kinds of long-term services and supports, including nursing home care.

Limits on Enrollment into CHOICES Group 2

Not everyone who qualifies to enroll in CHOICES Group 2 may be able to enroll. There is an enrollment target for CHOICES Group 2. It's like a limit on the number of people who can be in the group at one time. (The number of people who can enroll is sometimes called "slots".) This helps to ensure that the program doesn't grow faster than the State's money to pay for home care. It also helps to ensure that there are enough home care providers to deliver needed services.

The enrollment target for the number of slots that can be filled in CHOICES Group 2 will be set by the State in TennCare Rules. It doesn't apply to people moving out of a nursing home. And, it **may** not apply to some people who are on TennCare that would have to go into a nursing home right away if less costly home care isn't available. We must decide if you would go into a nursing home right away and provide proof to TennCare. And, we must show TennCare that there are home care providers ready to start giving your care at home.

Some slots will be held back (or reserved) for emergencies. This includes things like when a person is leaving the hospital and will be admitted to a nursing home if home care isn't available. Reserved slots won't be used until all of the other slots have been filled. The number of reserved slots and the guidelines to qualify in one of those slots is in TennCare Rules. If the only slots left are reserved, you'll have to meet the guidelines for reserved slots to enroll in CHOICES Group 2.

If you don't meet the guidelines for reserved slots or there are no slots available and you qualify to enroll in CHOICES Group 2, your name will be placed on a waiting list. Or, you can choose to enroll in CHOICES Group 1 and receive nursing home care. There is no limit on the number of people that can be enrolled in Group 1 and go into a nursing home. (But, you don't have to receive nursing home care unless you want to. You can wait for home care instead.)

People enrolled in CHOICES Group 2 above the enrollment target must get the first slots that open up. (These are people who have moved out of nursing homes or people already on TennCare and would have gone into a nursing home right away if less costly home care wasn't available.) When everyone in CHOICES Group 2 is under the enrollment target and there are still slots available, TennCare can enroll from the waiting list based on need.

What long-term services and supports are covered in CHOICES?

The covered long-term services and supports you can receive in CHOICES depend on the CHOICES Group you're enrolled in. If you enroll in CHOICES, TennCare will tell you which CHOICES Group you're in. There are three (3) CHOICES Groups.

People in **CHOICES Group 1** receive **nursing home care.**

People in **CHOICES Group 2** need the level of care provided in a nursing home but receive **home care** (or HCBS) instead of nursing home care.

People in **CHOICES Group 3** receive **home care** (or HCBS) to prevent or delay the need for nursing home care.

Here are the kinds of home care covered in CHOICES Group 2 and Group 3. Some of these services have limits. This means that TennCare will pay for only a certain amount of these services. The kind and amount of care you get in CHOICES depends on your needs.

- **Personal care visits** (up to 2 visits per day, lasting no more than 4 hours per visit; there must be at least 4 hours between each visit.) – Someone will help you with personal care needs and support in the home, on the job, or in the community. Do you need this kind of personal care? If you do, the worker giving your personal care visits can also help with household chores like fixing meals, cleaning, or laundry. And they can run errands like grocery shopping or picking up your medicine.

  They can only help with those things **for you**, not for other family members who aren't in CHOICES. And they can only do those things if there's no one else that can do them for you.
- **Attendant care** (up to 1,080 hours per calendar year) – The same kinds of help you'd get with personal care visits, but for longer periods of time (more than 4 hours per visit or visits less than 4 hours apart). You can only get attendant care when your needs can't be met with shorter personal care visits.

  Do you need help with personal care **and also** need help with household chores or errands? If so, your attendant care limit increases to up to 1,400 hours per calendar year. This higher limit is **only** for people who **also** need help with household chores or errands. How much attendant care you get depends on your needs.

- **Home-delivered meals** (up to 1 meal per day).
- **Personal Emergency Response System** – A call button so you can get help in an emergency when your caregiver is not around.
- **Adult day care** (up to 2,080 hours per calendar year) – A place that provides supervised care and activities during the day.
- **In-home respite care** (up to 216 hours per calendar year) – Someone to come and stay with you in your home for a short time so your caregiver can get some rest.
- **In-patient respite care** (up to 9 days per calendar year) – A short stay in a nursing home or assisted care living facility so your caregiver can get some rest.
- **Assistive technology** (up to $900 per calendar year) – Certain low-cost items or devices that help you do things easier or safer in your home like grabbers to reach things.
- **Minor home modifications** (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime) – Certain changes to your home that will help you get around easier and safer in your home like grab bars or a wheelchair ramp.
- **Pest control** (up to 9 units per calendar year) - Spraying your home for bugs or mice.
- **Assisted Care Living Facility** – A place you live that helps with personal care needs, homemaker services and taking your medicine. You must pay for your room and board.
- **Critical Adult Care Home** – A home where you and no more than 4 other people live with a health care professional that takes care of special health and long-term care needs. (Under state law, available only for people who are ventilator dependent or who have traumatic brain injury. You must pay for your room and board.) Critical Adult Care Homes are available for Group 2 members ONLY.
- **Companion Care** – Someone you hire who lives with you in your home to help with personal care or light housekeeping whenever you need it. (Available only for people in Consumer Direction who are in Group 2 and who need care off and on during the day and night that can’t be provided by unpaid caregivers. And only when it costs no more than other kinds of home care that would meet your needs.)
- **Community Living Supports** (**CLS**) – A shared home or apartment where you and no more than 3 other people live. The level of support provided depends on your needs and can include hands-on assistance, supervision, transportation and other supports needed to remain in the community.
- **Community Living Supports – Family Model** (**CLS-FM**) – A shared home or apartment where you and no more than 3 other people live with a trained host family. The level of support provided depends on your needs and can include hands-on assistance, supervision, transportation and other supports needed to remain in the community.

Care Coordination and Role of the Care Coordinator

In CHOICES, we are responsible for managing all of your physical health, behavioral health (mental health, alcohol or drug abuse) and long-term services and supports needs, and the services that you receive to address these needs. This is called care coordination.

These functions are carried out by a Care Coordinator. We will assign you a Care Coordinator when you enroll in CHOICES. Your Care Coordinator will play a very important role.
Your Care Coordinator is your primary contact person and is the first person that you should go to if you have any questions about your services.

Your Care Coordinator will…

- Provide information about CHOICES and answer your questions.
- Help you get the right kind of long-term services and supports in the right setting for you to address your needs.
- Coordinate all of your physical health, behavioral health (mental health, alcohol or drug abuse) and long-term services and supports needs.
- Help to fix problems and answer questions that you have about your care.
- Check at least once a year to make sure that you continue to need the level of care provided in a nursing home or, for Group 3, continue to be "at risk" of going into a nursing home.
- Communicate with your providers to make sure they know what's happening with your health care and to coordinate your service delivery.

Other tasks performed by the Care Coordinator will vary slightly depending on the CHOICES Group you're enrolled in.

If you receive nursing home care in CHOICES Group 1, your Care Coordinator will…

- Be part of the care planning process with the nursing home where you live.
- Perform any additional needs assessment that may be helpful in managing your health and long-term services and supports needs.
- Supplement (or add to) the nursing home's plan of care if there are things Amerigroup can do to help manage health problems or coordinate other kinds of physical and behavioral health (mental health, alcohol or drug abuse) care you need.
- Conduct face-to-face visits at least every 6 months.
- Coordinate with the nursing home when you need services the nursing home isn't responsible for providing.
- Determine if you're interested and able to move from the nursing home to the community and if so, help make sure this happens timely.

If you receive home care in CHOICES Group 2 or Group 3, your Care Coordinator will work with you to…

- Do a comprehensive, individual assessment of your health and long-term services and supports needs; and
- Develop a **Person-Centered Support Plan.**

This is your plan that helps guide the services and supports you will receive. Your support plan tells the people who will support you:

- **what is important to you** — the things that really matter to you
- **what is important for you** — the supports you need to stay healthy and safe, and achieve your goals, and
- **how to support you** to have those things in your life.

Your support plan must include:

- your strengths and needs
- the goals you want to reach
- the services and supports (paid and unpaid) you will receive to help you meet your goals
- how often you will receive those service and supports
- who will provide them, and
- the settings (or places) they will be provided.

Your Care Coordinator helps develop your support plan.

Your Care Coordinator will help you to:

- identify the services and supports you need
- explore employment options and ways to be part of your community and build relationships
- decide what services and supports you will need to meet your needs and reach your goals
- develop and access other services and unpaid supports to help too
- understand all of the services, providers and settings you can choose from
- choose the services you will receive, your provider for each service, and settings (places) where you will receive those services
- write your support plan based on your CHOICES, preferences, and support needs, and
- make sure you get the services in your support plan.

Your support plan is very important. CHOICES can only pay for covered services that are part of an approved support plan.

How your support plan is developed is also very important. Your support plan should be developed in a way that makes sure:

- You get to lead the planning process.
- You receive the help you need to lead the planning process.
- You get to make choices and to have the information you need to make those choices.
- You have help from family, friends, advocates or anyone else you choose.
- You get to speak for yourself.
- You can have someone to speak for you and choose that person.
- You have and use an interpreter if the language you speak or understand is not English.

Your support plan should also be developed in a way that makes sure:

- You get to talk with your Care Coordinator before the planning meeting if you want to.
- You get to pick who to invite to the meeting (and decide if you **don't** want someone there).
- The planning meeting is set at times and places that work best for you.

- You get to help choose service providers **before** services begin, and at any time during the year if you want to change providers. Amerigroup will try to give you the providers you want. (The provider must be contracted with your MCO and willing and able to provide your services.)
- You can choose to direct (or stop directing) some or all of the services that are part of Consumer Direction at any time.
- You sign your support plan.
- And, everyone who will provide services and supports (paid and unpaid) signs your support plan saying they are committed to implement your plan as written.

Your support plan is usually in effect for a year. But you can ask to change your support plan anytime during the year if your needs change or your situation changes.

Your Care Coordinator will also…
Make sure your plan of care is carried out and working the way that it needs to.

- Monitor to make sure you are getting what you need and that gaps in care are addressed right away.
- Contact you by telephone at least once every month and visit you in person at least once every 3 months if you are in Group 2 or contact you by telephone at least once every 3 months and visit you in person at least once every 6 months if you are in Group 3.
- Make sure the home care services you receive are based on your goals, needs and preferences and do not cost more than nursing home care, if you are in Group 2, or more than $15,000 if you are in Group 3.

We will tell you who your Care Coordinator is and how to reach them. If your Care Coordinator won't be assigned soon after you enroll in CHOICES, we will send a letter that says how to reach the Care Coordination Unit for help until your Care Coordinator is assigned.

Requesting a TennCare Review

If you're in CHOICES Group 2 or Group 3, you can ask TennCare to review your needs assessment or support plan if you have concerns and think you're not getting the services you need. TennCare will review the assessment or plan of care and the information gathered by your Care Coordinator. If TennCare thinks you're right, they'll work with us to fix the problem. If TennCare thinks you are getting the services you need, they'll send you a letter that says why.

To request an objective review of your needs assessment and support plan, you must submit a written request to:

TennCare Division of Long-Term Services and Supports
c/o CHOICES Review
310 Great Circle Road
Nashville, TN 37243

Keep a copy of your request. Write down the date that you sent it to TennCare.

Or, **fax** your request to **1-615-532-9140**. **Keep the page** that shows your fax went through.

Changing Care Coordinators

If you're unhappy with your Care Coordinator and would like a different one, you can ask us. You can have a new Care Coordinator if one is available. That doesn't mean you can pick whoever you want to be your Care Coordinator. We must be able to meet the needs of all CHOICES members and assign staff in a way that allows us to do that. To ask for a different Care Coordinator, call us at **1-866-840-4991**. Tell us why you want to change Care Coordinators. If we can't give you a new Care Coordinator, we'll tell you why. And, we'll help to address any problems or concerns you have with your Care Coordinator.

There may be times when we will have to change your Care Coordinator. This may happen if your Care Coordinator is no longer with Amerigroup, is temporarily not working, or has too many members to give them the attention they need. If this happens, we will send you a letter that says who your new Care Coordinator will be and how to contact them.

If you're in CHOICES, you can contact your Care Coordinator anytime you have a question or concern about your health care – you do not need to wait until a home visit or a phone call. You should contact your Care Coordinator anytime you have a change in your health condition or other things that may affect the kind or amount of care you need. If you need help after regular business hours that won't wait until the next day, you can call us at **1-866-840-4991**.

CHOICES Consumer Advocate

In addition to your Care Coordinator, there is another person at Amerigroup to help you. This person is the CHOICES Consumer Advocate. The CHOICES Consumer Advocate is available to:

- Provide information about the CHOICES program.
- Help you figure out how things work at Amerigroup, like filing a complaint, changing Care Coordinators or getting the care you need.
- Make referrals to the right Amerigroup staff.
- Help fix problems with your care.

To reach the Amerigroup CHOICES Consumer Advocate, call us at **1-866-840-4991**. Ask to speak with the CHOICES Consumer Advocate.

Freedom of Choice

In CHOICES, if you need the level of care provided in a nursing home, you have the right to choose to get care:

- In your home,
- Or in another place in the community (like an assisted living facility or critical adult care home),
- Or in a nursing home.

To get care in your home or in the community, you must qualify and be able to enroll in CHOICES Group 2 or CHOICES Group 3. (See ***Who can qualify to enroll in CHOICES?)***

If you're in a nursing home, you may be able to move from your nursing home to your own home and receive services if you want to. If you're interested in moving out of the nursing home into the community, talk with your Care Coordinator.

To get care in your home or in the community, we must be able to safely meet your needs in that setting. And, for CHOICES Group 2 the cost of your care can't be more than the cost of your care in a nursing home. That includes the cost of your home care **and** any home health or nursing care you may need. For CHOICES Group 3, the cost of your care can't be more than $15,000 per year. Minor home modifications, and any home health or nursing care you might need don't count against the $15,000 limit. The actual kind and amount of care you will receive depends on your needs.

What if you qualify for nursing home care but don't want to leave the nursing home and move to the community? Then, we won't make you, even if we think care in the community would cost less. As long as you qualify for nursing home care, you can choose to receive it.

You can change your choice at any time as long as you qualify and can enroll to receive care in the setting you pick.

In CHOICES, you can also help choose the providers who will give your care. This could be an assisted living or nursing home, or the agency who will give your care at home. You may also be able to hire your own workers for some kinds of care (called Consumer Direction).

The provider you choose must be willing and able to give your care. Your Care Coordinator will try to help you get the provider you pick. But, if you don't get the **provider** you want, you can't appeal and get a fair hearing. If you don't get the **services** you think you need, then you can file an appeal.

Using Long-Term Services and Supports Providers Who Work with Amerigroup

Just like physical and behavioral health services, you must use providers who work with us for most long-term services and supports. You can find the Provider Directory online at **www.myamerigroup.com/TN**. Or call us at **1-800-600-4441** to get a list. Providers may have signed up or dropped out after the list was printed. But, the online Provider Directory is updated every week. You can also call us at **1-800-600-4441** to find out if a provider is in our network.

In most cases, you must receive services from a long-term services and supports provider on this list so that TennCare will pay for your long-term services and supports. However, there are times when TennCare will pay for you to get care from a long-term services and supports provider who does not usually work with us. But, we must first say that it is OK to use a long-term services and supports provider who does not usually work with Amerigroup.

Prior Authorization of Long-Term Services and Supports

Sometimes you may have to get an **OK** from us for your physical or behavioral health (mental health, alcohol or drug abuse) services before you receive them even if a doctor says you need the services. This is called prior authorization. Services that must have a prior authorization before you receive them will only be paid for if we say OK **before** the services are provided.

All long-term services and supports must be approved before we will pay for them. All **home care services** must be approved **before you receive them**. Nursing home care may sometimes start before you get an **OK**, but you still need an **OK** before we will pay for it. We will not pay for any long-term services and supports unless you have an **OK**.

Consumer Direction

Consumer Direction is a way of getting some of the kinds of home care you need. It offers more choice and control over **who** gives your home care and **how** your care is given. The services available through Consumer Direction are:

- Personal care visits;
- Attendant care;
- In-home respite; and
- Companion care (Only if you qualify for and are enrolled in CHOICES Group 2)

In Consumer Direction, you actually employ the people who give some of your home care services — they work **for you** (instead of a provider). You must be able to do the things that an employer would do. These include things like:

Hiring and training your workers:
- Find, interview and hire workers to provide care for you
- Define workers' job duties
- Develop a job description for your workers
- Train workers to deliver your care based on your needs and preferences

Setting and managing your workers' schedule:
- Set the schedule at which your workers will give your care
- Make sure your workers use the call-in system to log in and out every time they work
- Make sure your workers provide *only* as much care as you are approved to receive
- Make sure that no hourly worker gives you more than 40 hours of care in a week

Supervising your workers:
- Supervise your workers
- Evaluate your workers' job performance
- Address problems or concerns with your workers' performance
- Fire a worker when needed

Overseeing workers' pay and service notes:
- Decide how much your workers will be paid (within limits set by the State)
- Review the time your workers report to be sure it's right
- Ensure there are good notes kept in your home about the care your workers provide

Having and using a back-up plan when needed:
- Develop a back-up plan to address times that a scheduled worker doesn't show up (you can't decide to just go without services)
- Activate the back-up plan when needed

What if you can't do some or all of these things? Then you can choose a family member, friend, or someone close to you to do these things for you. It's called a "Representative for Consumer Direction." It's important that you pick someone who knows you very well that you can depend on. To be your Representative for Consumer Direction, the person must:

- Be at least 18 years of age.
- Know you very well.
- Understand the kinds of care you need and how you want care to be given.
- Know your schedule and routine.

- Know your health care needs and the medicine you take.
- Be willing and able to do **all** of the things that are required to be in Consumer Direction.
- Live with you in your home **or** be present in your home often enough to supervise staff. This usually means at least part of every worker's shift. But, it may be less as long as it's enough to be sure you're getting the quality of care you need.
- Be willing to sign a Representative Agreement, saying they agree to do these things.

Your Representative cannot get paid for doing these things.
You or your Representative will have help doing some of the things you must do as an employer. The help will be provided by Public Partnerships, LLC. There are 2 kinds of help you will receive:

1. Public Partnerships, LLC will help you and your workers fill out all of the paperwork that you must complete. They will pay your workers for the care they give. And, they will fill out and file the payroll tax forms that you must fill out as an employer.

2. Public Partnerships, LLC will hire or contract with a Supports Broker for you. A Supports Broker is a person who will help you with the other kinds of things you must do as an employer. These are things like:
   - Writing job descriptions;
   - Helping you and your workers with paperwork and training;
   - Scheduling workers based on your support plan; and
   - Developing an initial back-up plan to address times when a scheduled worker doesn't show up.

But, your Supports Broker **can't** help you supervise your workers. You or your Representative must be able to do that by yourself.

The kind and amount of care you'll get depends on what you need. Those services are listed in your support plan. You won't be able to get more services by choosing to be in Consumer Direction. You can only get the services you need that are listed in your support plan.

You can choose to get some of these services through Consumer Direction **and** get some home care from providers that work with your TennCare health plan. But, you must use providers that work with Amerigroup for care that you can't get through Consumer Direction.

Can you pay a family member or friend to provide care in Consumer Direction? Yes, you can pay a family member, but you **cannot:**
- Pay your spouse to provide care;
- Pay someone who lives with you to provide Attendant Care, Personal Care, or In-home Respite services;
- Pay an immediate family member to provide Companion Care. An immediate family member is a spouse, parent, grandparent, child, grandchild, sibling, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, and son-in-law. Adopted and step members are included in this definition;
- Pay someone who lives with you now or in the last 5 years to provide Companion Care.

And, CHOICES can't pay family members or others to provide care they would have given for free. CHOICES only pays for care to meet needs that **can't** be met by family members or others who help you. The services you need are listed in your support plan.

If you're in CHOICES and need services that can be consumer directed, your Care Coordinator will talk with you about Consumer Direction. If you want to be in Consumer Direction, your Care Coordinator will work with you to decide which of the services you will direct and start the process to enroll you in Consumer Direction. Until Consumer Direction is set up, you will get the services that are in your support plan from a provider who works with Amerigroup, unless **you choose** to wait for your Consumer Directed workers to start. If you choose to wait for your Consumer Directed workers to start, you must have supports in place to give you the care you need.

You can decide to be in Consumer Direction at any time. If you are directing one or more services and decide not to be in Consumer Direction any more, you will **not** stop getting long-term services and supports. You will still be in CHOICES. You'll get the services you need from a provider who works with Amerigroup instead.

Self-Direction of Health Care Tasks

If you're in Consumer Direction, you may also choose to have consumer directed workers perform certain kinds of health care tasks for you. Health care tasks are routine things like taking prescribed drugs that most people do for themselves every day. Usually, if you can't perform health care tasks yourself and don't have a family member to do them for you, they must be performed by a licensed nurse. But, in Consumer Direction, if your doctor says it's OK, you can have your consumer directed workers do certain kinds of health care tasks for you. You (or your Representative) must be able to train your workers on how to do each health care task, and must supervise them in performing the task.

Please talk with your Care Coordinator if you have any questions about self-direction of health care tasks.

Paying for your CHOICES Long-Term Services and Supports

You may have to pay part of the cost of your care in CHOICES. It's called **"patient liability."** The amount you pay depends on your income. If you have patient liability, you **must** pay it in CHOICES. If you get care in an assisted living or adult care home, or in a nursing home, you will pay your patient liability to that home. If you get care in your own home, you will pay your patient liability to Amerigroup.

Do you have medical bills for care you got <u>before</u> your TennCare started? This includes care in a nursing home, or Medicare co-pays or deductibles.

Or, do you have medical bills for care you got <u>after</u> TennCare started that TennCare doesn't cover? This includes eye glasses, hearing aids, and dental care for adults.

We may be able to subtract those bills from the patient liability you owe each month. This means your patient liability will be less. (It can even be zero.) We'll keep subtracting those bills until the total cost of your medical bills has been subtracted.

The bills must be for care you got in the 3 months before the month you applied to TennCare. For example, if you apply for TennCare in April, the bills must be for January, February, and March.

These can be bills you've already paid. Or they can be bills you haven't paid yet. But you must be expected to pay them. (You don't have other insurance to pay for them.) What if a family member or someone else paid these bills? Send them only if they expect you to pay them back.

If you have medical bills like this, send them to TennCare. There are 2 ways to get them to us.

By mail: Tennessee Health Connection
P.O. Box 305240
Nashville, TN 37230-5240

By fax: 1-855-315-0669

On each page you send, be sure to write "for patient liability" and include your name and Social Security number.

What if you DON'T pay the patient liability you owe? 4 things could happen:

1. Your CHOICES care provider could decide not to provide your care anymore. If you get care in an assisted living or adult care home, or in a nursing home, they could discharge you. Before they do, they must send you a letter that says why you're being discharged. If you think they're wrong about owing them money, you can appeal.
2. **And** if you don't pay your patient liability, other providers may not be willing to give your care either. If that happens, Amerigroup could decide not to be your health plan for CHOICES anymore. We can't meet your needs if we can't find any providers willing to give you care. We must send you a letter that says why we can't be your health plan for CHOICES anymore. If you think we're wrong, you can appeal.
3. **And** if you don't pay your patient liability, other TennCare health plans may not be willing to be your health plan for CHOICES either. If that happens, you may not be able to stay in CHOICES. You may not get **any** long-term services and supports from TennCare. If you can't stay in CHOICES, TennCare will send you a letter that says why. If you think they're wrong, you can appeal.
4. **And** if you can't stay in CHOICES, you may not qualify for TennCare anymore. If the only way you qualify for TennCare is because you get long-term services and supports, you could lose your TennCare too. Before your TennCare ends, you'll get a letter that says how to appeal if you think it's a mistake.

If you have patient liability, it's very important that you pay it.

Do you have Medicare or other insurance that helps pay for your long-term services and supports? If you do, that insurance must pay **first.** TennCare can't pay for care that's covered by Medicare or other insurance. What if you have long-term services and supports insurance that pays **you**? Then you must pay the amount you get to help cover the cost of your care. If you live in an assisted living or adult care home, or in a nursing home, you'll pay the amount you get to that home. If you get care in your own home, your Care Coordinator will tell you how to pay the insurance money you get. This **won't** lower the amount of any patient liability you owe. You must pay any long-term services and supports insurance you get **and** your patient liability to help cover the cost of your care. But, you won't pay more than the total cost of long-term services and supports you receive that month.

What if you receive Aid and Attendance Benefits through the Department of Veterans Affairs? If you do, it is important that you tell your Care Coordinator. Your Care Coordinator will give you important information that will help you make choices about how you will receive the long-term services and supports that you need.

Disenrollment from CHOICES

Your enrollment in CHOICES and receipt of long-term services and supports can end for several reasons and may vary depending on the CHOICES Group that you are enrolled in. We can recommend a member's disenrollment from CHOICES but TennCare will make the final decision. Some of the reasons you could be disenrolled from CHOICES include:

- You no longer qualify for Medicaid.
- You no longer need the level of care provided in a nursing home and you're not at risk of going into a nursing home.
- You no longer need and aren't receiving **any** long-term services and supports.
- You do not pay your patient liability.

If you're in Group 2 or Group 3, your enrollment in CHOICES can also end if…
We decide we can no longer safely meet your needs in the home or community, and you refuse to move to a nursing home. Reasons we may not be able to safely meet your needs include things like:

- You refuse to allow a Care Coordinator into your home. If a Care Coordinator can't visit you in your home, we can't be sure that you're safe and healthy.
- The risk of harm to you or to people providing care in your home is too great.
- Even though there are providers available to provide care, none of those providers are willing to provide your care.
- You refuse to receive services that are identified in your person-centered support plan as needed services.

If you're in Group 2, you can also be disenrolled if:
The cost of care you need in the home or community will be more than the cost of nursing home care. The cost of care includes any home health or private duty nursing you may need.

Your Care Coordinator will check regularly to make sure that the care you receive in your own home or in the community (including the cost of home health and private duty nursing) does not exceed the cost of nursing home care.

- If we decide that home care will cost more than nursing home care, your Care Coordinator will work with you to try to put together a support plan that will safely and cost-effectively meet your needs. If we decide it's not possible to safely serve you in your home or in the community for no more than the cost of nursing home care, your Care Coordinator will help you move to a nursing home of your choice who works with Amerigroup. If you choose not to move to a nursing home, you'll no longer be able to receive services in your own home or in the community. You'll be disenrolled from CHOICES.

If you're in Group 3:
We must be able to safely meet your needs with the care you can get in CHOICES Group 3. This includes CHOICES home care up to $15,000 per year (not counting minor home modifications), other Medicaid services you qualify to receive from your MCO, services you can get through Medicare, private insurance or other funding sources, and unpaid care provided by family members and friends. If we decide your needs can't be met with the care you can get in Group 3,

TennCare will see if you qualify to move to CHOICES Group 2 for more home care or CHOICES Group 1 for nursing home care. What if your needs can't be met at home or in the community (even with home care up to the cost of nursing home care) and you choose not to move to a nursing home? Then, you will be disenrolled from CHOICES.

If you're disenrolled from CHOICES, you'll stay on TennCare as long as you still qualify for Medicaid. However, you'll no longer receive **any** long-term services and supports paid for by TennCare. You'll get a letter that says why your CHOICES is ending and how to appeal if you think it's a mistake.

If the **only** way you qualify for Medicaid is because you receive long-term services and supports and you're disenrolled from CHOICES, your TennCare may end too. Before it does, you'll get a letter that says why. You'll get a chance to qualify in another one of the groups that Medicaid covers.

Long-Term Care Ombudsman

The State's Long-Term Care Ombudsman program offers assistance to persons living in nursing homes or other community-based residential settings, like an assisted living or critical adult care home. A Long-Term Care Ombudsman does **not** work for the facility, the State, or Amerigroup. This helps them to be fair and objective in resolving problems and concerns.

The Long-Term Care Ombudsman in each area of the State can:

- Provide information about admission to and discharge from long-term services and supports facilities.
- Provide education about resident rights and responsibilities.
- Help residents and their families resolve questions or problems they have been unable to address on their own with the facility. Concerns can include things like:
    - Quality of care;
    - Resident rights; or
    - Admissions, transfers, and discharges

To find out more about the Long-Term Care Ombudsman program, or to contact the Ombudsman in your area, call the Tennessee Commission on Aging and Disability for free at **1-877-236-0013**.

Ombudsman for People Receiving Community Living Supports in CHOICES

Community Living Supports are services for people who can no longer live alone, but don't have family that can give the help they need. If you're in CHOICES and want Community Living Supports, you will have an Ombudsman to help you. This Ombudsman works for the Area Agency on Aging and Disability in your area. Amerigroup will give them your name and they will call you. Your Ombudsman can help you:

- Understand your rights and responsibilities. This includes your right to decide if you want these services, who provides your services, where you live, and who you live with.
- Exercise your rights when you need help.
- Fix quality concerns or other problems you can't fix with your provider or health plan.
- Contact other places that can help you when you need it.
- Understand, identify and report abuse, neglect, or exploitation.

Employment and Community First CHOICES

What is Employment and Community First CHOICES?

Employment and Community First CHOICES is for people of all ages who have an intellectual or developmental disability (I/DD). This includes people who have significant disabilities.

Services help people with I/DD gain as much independence as possible. People are supported to live with their family or in the community, not in an institution. Residential services are available for adults with I/DD who do not live with family but need supports where they live.

Employment and Community First CHOICES can help the person with I/DD explore the possibility of working. Services can also help people learn skills for work, find a job, and keep a job. This could be a part-time job, a full-time job or self-employment. Working helps people earn money, learn new skills, meet new people, and play an important role in their communities. Work can also help people stay healthy and build self-confidence.

Other services help people learn and do things at home and in the community that help people achieve their goals. If a person lives at home with their family, the services help the family support the person to become as independent as possible. Services also help people get actively involved in their communities and include peer supports for the person and for their family.

Amerigroup is your TennCare health plan. We're sometimes called your **M**anaged **C**are **O**rganization or **MCO**. We will help you get the services you need in Employment and Community First CHOICES. We will also help you with your physical or behavioral health care (mental health, alcohol and drug abuse services).

Your Support Coordinator

In Employment and Community First CHOICES, you will have a Support Coordinator. You should know who your Support Coordinator is and how to contact them. They will help you get the health, mental health and support services you need most to live in the community and help you reach your goals.

Not sure who your Support Coordinator is or how to contact them? You can call us at **1-866-840-4991**.

If you want to pick a new Support Coordinator, call us at **1-866-840-4991**. This doesn't mean you can pick whoever you want to be your Support Coordinator. Amerigroup must meet the needs of everyone in the program and assign staff in a way that allows us to do that. If you call, tell us why you want to change Support Coordinators. If we can't give you a new Support Coordinator, we'll tell you why. And, we'll address any problems or concerns you have with your Support Coordinator.

There may be times when Amerigroup will have to change your Support Coordinator. This may happen if your Support Coordinator is no longer with Amerigroup, is off work for a while, or has too many members to give them the attention they need. If this happens, Amerigroup will send you a letter that says who your new Support Coordinator will be and how to contact them.

You can contact your Support Coordinator anytime you have a question or concern about your services and supports. You do not need to wait until they visit or call you. You should contact your Support Coordinator anytime you have a change in your health condition or other things that may affect the kind or amount of support you need. What if you need help after regular business hours that won't wait until the next day? You can call Amerigroup at **1-866-840-4991**.

Member Advocate for Employment and Community First CHOICES

In addition to your Support Coordinator, there is another person at Amerigroup to help you. This person is the Member Advocate for Employment and Community First CHOICES. Your Member Advocate is available to:

- Provide information and answer questions about Employment and Community First CHOICES.
- Help solve problems with your services and supports.
- Help you file a complaint, ask to change Support Coordinators or get the services and supports you need.
- Help you talk to the right Amerigroup staff.

To reach the Amerigroup Member Advocate for Employment and Community First CHOICES, call Amerigroup at **1-866-840-4991**. Ask to speak with the Member Advocate for Employment and Community First CHOICES.

Your Person-Centered Support Plan

In Employment and Community First CHOICES, you must have a **P**erson-**C**entered **S**upport **P**lan (**PCSP** or "support plan" for short). This is your plan that helps guide the services and supports you will receive. Your support plan tells the people who will support you:

- **what is important to you** — the things that really matter to you
- **what is important for you** — the supports you need to stay healthy and safe, and achieve your goals, and
- **how to support you** to have those things in your life.

Your support plan must include:

- your strengths and needs
- the goals you want to reach
- the services and supports (paid and unpaid) you will receive to help you meet your goals
- how often you will receive those services and supports
- who will provide them, and
- the settings (or places) they will be provided.

Your Support Coordinator helps develop your support plan.

Your Support Coordinator will help you to:

- identify the services and supports you need
- explore employment options and ways to be part of your community and build relationships
- decide what services and supports you will need to meet your needs and reach your goals
- develop and access other services and unpaid supports to help too
- understand all of the services, providers and settings you can choose from
- choose the services you will receive, your provider for each service, and settings (places) where you will receive those services
- write your support plan based on your choices, preferences, and support needs, and
- make sure you get the services in your support plan.

Your support plan is very important. Employment and Community First CHOICES can only pay for covered services that are part of an approved support plan.

How your support plan is developed is also very important. Your support plan should be developed in a way that makes sure:

- You get to lead the planning process.
- You receive the help you need to lead the planning process.
- You get to make choices and to have the information you need to make those choices.
- You have help from family, friends, advocates or anyone else you choose.
- You get to speak for yourself.
- You can have someone to speak for you and choose that person.
- You have and use an interpreter if the language you speak or understand is not English.

Your support plan should also be developed in a way that makes sure:

- You get to talk with your Support Coordinator before the planning meeting if you want to.
- You get to pick who to invite to the meeting (and decide if you **don't** want someone there).
- The planning meeting is set at times and places that work best for you.
- You get to help choose service providers **before** services begin, and at any time during the year if you want to change providers. Amerigroup will try to give you the providers you want. (The provider must be contracted with your MCO and willing and able to provide your services.)
- You can choose to direct (or stop directing) some or all of the services that are part of Consumer Direction at any time.
- You sign your support plan.
- And, everyone who will provide services and supports (paid and unpaid) signs your support plan saying they are committed to implement your plan as written.

Your support plan is usually in effect for a year. But you can ask to change your support plan anytime during the year if your needs change or your situation changes.

What services are covered in Employment and Community First CHOICES?

The services you can receive in Employment and Community First CHOICES depend on which benefit group you're in. There are **three benefit groups:**

1. **Essential Family Supports** or "Family Support services" for short. (This is sometimes called "CHOICES Group **4**.") Family Support services are **only** for people who live at home with their family. They will help you plan for and get a job, and live as independently as possible in the community. They will help you do things in the community that you want to do — to help you build relationships and reach your goals. They will also help your family support you in planning for and reaching your goals.

   The total cost of Family Support services you get can't be more than $15,000 each year. This is your yearly limit or "cost cap." It starts on January 1st each year and ends on December 31st each year. Only in Essential Family Supports, your cost cap does not include the cost of any Minor Home Modifications. We also won't count the cost of Family-to-Family Support. To find out more about these and other services, read the chart at the end of these handbook pages.

2. **Essential Supports for Employment and Independent Living** or "Essential Support services" for short. (This is sometimes called "CHOICES Group **5**.") These services are **only** for adults age 21 and older.[3] They will help you get or keep a job and live as independently as possible in the community. They will help you do things in the community that you want to do — to help you build relationships and reach your goals.

   The total cost of essential Support services you get can't be more than $30,000 each year. This is your yearly limit or "cost cap." It starts on January 1st each year and ends on December 31 each year. What if you have an emergency and need more services to stay in the community? You may be able to get more Essential Support services for that year. But they can't cost more than $6,000.

   No one can get more than $36,000 of Essential Support services per calendar year.

3. **Comprehensive Supports for Employment and Community Living** or "Comprehensive Support services" for short. (This is sometimes called "CHOICES Group **6**.") These services are **only** for adults age 21 and older who would qualify to get care in a nursing home.[4] (But these services are provided **in the community**.) They will help you get or keep a job and live as independently as possible in the community. They will help you do things in the community that you want to do — to help you build relationships and reach your goals.

   You will have a limit (or "cost cap") on the total cost of Comprehensive Support services you can get each year. Your yearly cost cap is based on an assessment of your "level of need." Your "level of need" tell us how much support you need. Everyone in the Comprehensive Support services group (CHOICES Group 6) will have an assessed "level of need." The assessment is not done by TennCare or your health plan.

   - If you're assessed to have a **low or moderate** level of need: You will have a cost cap of **$45,000** each year.
   - If you're assessed to have a **high** level of need: You will have a cost cap of **$60,000** each year.
   - **Only if you're assessed to have exceptional medical and/or behavioral needs**: you will have a higher cost cap. The amount is based on the average yearly cost of care in an institution you would qualify to receive.
     - If you have an **intellectual disability:** Your cost cap is based on the average yearly cost of services in a private ICF/IID (Intermediate Care Facility for Individuals with Intellectual Disabilities).
     - If you have a **developmental disability:** Your cost cap is based on the average yearly cost of nursing home care **plus** the average cost of special services a person with a developmental disability would need in a nursing home.

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[3] On a case-by-case basis, TennCare may grant an exception to permit adults ages eighteen (18) to twenty (20) with I/DD not living at home with family, including young adults with I/DD transitioning out of State custody, to enroll in Group 6, if they meet eligibility criteria.

[4] On a case-by-case basis, TennCare may grant an exception to permit adults ages eighteen (18) to twenty (20) with I/DD not living at home with family, including young adults with I/DD transitioning out of State custody, to enroll in Group 6, if they meet eligibility criteria.

These average yearly costs change every year.

This **doesn't** mean you will get services in an ICF/IID or nursing home. Employment and Community First CHOICES provides services **in the community.** These amounts are used to set the yearly limit on the total cost of support services you can receive in the community — your cost cap (but **only** when you have exceptional medical or behavioral needs).

If your cost cap is based on the cost of care in an ICF/IID or nursing home, any home health or private duty nursing TennCare pays for **will also count** against your cap. This is the only time other TennCare services count against your cost cap. **Except** for home health and private duty nursing for people with exceptional medical or behavioral needs, other TennCare services don't count against your cost cap.

TennCare will get your assessment and tell you how much your cost cap will be. If you have questions, ask your Support Coordinator.

For the first year that you're in Employment and Community First CHOICES, your cost cap will be "pro-rated." This means your yearly cost cap will be divided by the 365 days in a year and then multiplied by the number of days you will actually be in the program that year.

No matter how much your cost cap is, it **doesn't** mean that you will get services up to the cost cap amount. Employment and Community First CHOICES will only pay for services you must have to meet your needs at home or in your community. This includes services you need to work, live as independently as possible, be part of your community, and reach your goals. We'll help you use or develop "natural supports" when you can. These are people who can help provide the support you need without being paid — like family, friends and co-workers. Using natural supports can help you build relationships and be part of your community.

Services you get in Employment and Community First CHOICES will not take the place of support you get from family and friends or services you already receive. If you get help from community programs, services paid for by Medicare or other insurance, or have a family member that helps support you, we don't want to replace those with paid services through Employment and Community First CHOICES. Instead, your services in Employment and Community First CHOICES will work together with the support you already get to help you meet your employment and community living goals. We want to provide services as cost-effectively as possible. This will allow more people who need support to get help. This is how the program was designed based on input from people who need services and their families.

What if your needs change and you need more support? Tell your Support Coordinator. Your Support Coordinator will help you take a look at your support plan. You may get different services based on how your needs have changed.

What if you need services that cost more than your yearly limit or think you should qualify for a higher cost cap? You can ask for a new assessment. If the assessment shows that your needs have changed, your cost cap could change too. But you won't be able to get services that cost more than your assessment says you need.

Requesting a TennCare Review

If you're in any Employment and Community First CHOICES group, you can ask TennCare to review your needs assessment or support plan if you think you're not getting the services you need. TennCare will review the assessment or support plan and the information gathered by your Support Coordinator. If TennCare thinks you're right, they'll work with Amerigroup to fix the problem. If TennCare thinks you are getting the services you need, they'll send you a letter that says why. To request an objective review of your needs assessment or support plan, you can mail a written request to:

TennCare Division of Long-Term Services and Supports
c/o Employment and Community First CHOICES Review
310 Great Circle Road
Nashville, TN 37243

Keep a copy of your request. Write down the date that you sent it to TennCare.

Or, **fax** your request to **615-532-9140**. **Keep the page** that shows your fax went through.

You also have the right to file an appeal. Here are some of your appeal rights:

- You can appeal if you think an assessment doesn't really match your needs and you think you should get more and/or different services.
- You can appeal if you don't agree with the services in your support plan.
- You can appeal if a covered service that you want and need isn't in your support plan.
- You can appeal if your request to have your support plan changed is denied, or your support plan is not changed enough to meet your needs.
- And, you can appeal if a service is in your approved support plan, but you don't receive it, or there is a delay in getting it.

If you file an appeal, it doesn't mean that you will get the services you want. But, TennCare will take another look at what you're asking for. If TennCare agrees that the service is covered **and** that you need it, you will get the service.

What if TennCare decides the service isn't covered or that you don't need it? You may get a fair hearing. To get a fair hearing, the service(s) you want must be covered in the Employment and Community First benefit group you're in. That includes any limits on the service(s) and on the total cost of services you can receive — your yearly cost cap.

TennCare can only pay for services that are covered in the Employment and Community First benefit group you're in. If a service isn't covered, or if you want more of a service than is covered, TennCare can't pay for it.

If you file an appeal to keep a service you've been getting, you *may* be able to keep it during the appeal. To keep getting a service during your appeal, it must be a covered benefit. And, you must have an approved support plan. TennCare can only pay for services that are part of an approved support plan.

You can't get a service during your appeal:

- If the service isn't covered.
- You don't have an approved support plan that includes the service.
- Or, you want to start getting a new service.

There are 3 ways to file an appeal.

1. **Mail.** You can mail an appeal page or a letter about your problem to:

   TennCare Solutions
   P.O. Box 000593
   Nashville, TN 37202-0593

   You can get an appeal page from our website. Go to **tn.gov/tenncare**. Click "Members/Applicants" then click on "How to file a medical appeal". Or, to have TennCare mail you an appeal page, call them for free at **1-800-878-3192.**

2. **Fax.** You can fax your appeal page or letter for free to **1-888-345-5575.**

3. **Call.** You can call TennCare Solutions for free at **1-800-878-3192.**

We're here to help you Monday through Friday from 8 a.m. until 4:30 p.m. Central time.

Services in Employment and Community First CHOICES

The kinds of support services covered in Employment and Community First CHOICES are listed in a chart at the end of these handbook pages. Some of these services have limits. This means that TennCare will only pay for a certain amount of these services. The chart tells you how each service can help you, what benefit groups cover it, and the limits on that service. If you have questions about a service, ask your Support Coordinator.

Employment Supports

There are many different kinds of services to help you get and keep a job. They will help you:

- Decide if you want to work and the kinds of jobs you might like and be really good at.
- Try out certain jobs to see what they're like and what you need to do to get ready for those jobs.
- Write a plan to get a job (or start your own business) and carry out that plan.
- Have a job coach to support you when you start your job until you can do the job by yourself or with help from co-workers.
- Get a better job, earning more money.
- Understand how the money you earn from working will impact other benefits you get, including Social Security and TennCare.

Employment services are available to individuals of working age in all three benefit groups. In Tennessee, the working age starts at 16.

The goal in this program is "individual, integrated, competitive employment." Here is what that means.

"Individual" means that you are employed by yourself and not as part of a small group of people with disabilities. This doesn't mean you can't work with other people or be part of a team on your job. You could also be "self-employed." This means you have a business and work for yourself.

"Integrated" means your work (or your business if you're self-employed) is in the community. You work with (or provide services to) people who don't have disabilities.

"Competitive" means the wage you earn for your work (or from your business, after expenses) is *at least* the minimum wage. And it should be the same wage that is paid to people who don't have disabilities that do the same work.

For some people, a job may be "customized." This means that your employment provider helps find or develop a job that's just for you. They match the kinds of things you like and are good at with the needs of an employer. There will be a special agreement between you and your employer to make sure both of your needs are met. The employer may agree to change things about the job to make it work for you. You may only do parts of a job, share parts of the job with someone else, or do things that no one else does. The agreement may also cover things like:

- Where you work
- The hours you work
- The supports you need
- How much you're paid

If you have greater support needs, "customized employment" may help find a job that's right for you.

What if you don't think you want to work? Before you make up your mind, we want to help you explore the kinds of jobs you might like and be good at. We want to help you understand the benefits of work and answer any questions you have. This is called **Employment Informed Choice.** It means you have the facts you need to make a good decision about working.

There are 2 services you can get to help you make an informed choice about employment:

- **Exploration** – Helps you decide if you want to work and the kinds of jobs you might like and be really good at by visiting job sites that match your skills and interests. Also helps you (and your family) understand the benefits of working and helps answer your questions about work.

- **Peer-to-Peer Self-Direction, Employment and Community Support and Navigation** – Guidance and support from another person with disabilities who has experience and training to help you and answer your questions. Includes support to help you:
  - Direct your support plan.
  - Direct your services (hire and supervise your own staff in Consumer Direction).
  - **Think about and try employment** or community living options.

Are you between the ages of 16 and 62? You must complete the Employment Informed Choice process **before** you can get certain other kinds of Independent Community Living Supports. These include:

- **Community Integration Support Services** – Helps you do things in the community that you want to do. Take a class, join a club, volunteer, get or stay healthy, do something fun, build relationships, and reach your goals.
- **Independent Living Skills Training** – Helps you learn new things so you can live more independently. These skills can help you take care of yourself, your home, or your money.

To complete the Employment Informed Choice process, you must receive *at least* the Exploration service. You can also *choose* to receive the Peer-to-Peer Support service.

What if you get *at least* the Exploration service and still don't want to work right now? Then you must sign a page that says you've gotten all of the facts and still don't want to work. Then, if you need Community Integration Support Services or Independent Living Skills Training, you can get them. But they will be limited to no more than 20 hours a week **combined**. You can only get these services if you **don't** get residential services like Community Living Supports (including Family Model). If you get Community Living Supports, help to do these things are part of the residential service you receive.

Consumer Direction

Consumer Direction is a way of getting some of the kinds of supports you need in Employment and Community First CHOICES. Consumer Direction gives you more choice and control over WHO gives your support and HOW your support is given.

In Consumer Direction, you actually employ the people who give some of your support services — they work for you (instead of a provider). This means that you must do the things an employer would do – like hire, train, schedule, supervise, and even fire workers. You also have to be able to manage the services you need within your approved budget for each service.

What if you can't do some or all of these things? Then you can choose a family member, friend, or someone close to you to do these things for you. It's called a "Representative for Consumer Direction." If you decide to join Consumer Direction and need a Representative, your Support Coordinator will tell you who qualifies to be a Representative. The person you pick can't be paid to give any of your support services in Consumer Direction. It's important that you pick someone who knows you very well that you can depend on.

The services you can Consumer Direct are:
- **Personal Assistance**
- **Supportive Home Care**
- **Respite**
- **Community Transportation**

To get these services in Consumer Direction, they must be in your support plan. The kind and amount of services you'll get depends on what you need to support you and help you reach your goals.

You will have a budget for each service you choose to receive through Consumer Direction. The budget will be based on how much of that service your support plan says you need. Most services will have a monthly budget. This includes Personal Assistance or Supportive Home Care. You will schedule your workers to give you the supports you need. You can only pay workers up to the amount of your monthly budget for that service. Be sure you don't ask them to (or let them) provide more. If you use all of your monthly budget for a service in the first part of the month, you can't get more services approved for the rest of the month. If you can't manage your services within your monthly budget, you may not be able to stay in Consumer Direction.

Community Transportation also has a monthly budget. You can decide how to use your monthly transportation budget to pay for the help you need to go where you want to go. If you get respite through Consumer Direction, it will have a yearly budget (January 1st through December 31st of each year). You can pay workers to provide up to a total of 216 hours **or** 30 days each year (you have to pick **one**).

Can you pay a family member or friend to provide support in Consumer Direction?
Yes. The workers you hire can be people you know, including family members or friends. But TennCare won't pay family members or others to provide support they would have given for free. TennCare only pays for support to meet needs that **can't** be met by family members or others who help you. AND, you **can't** pay anyone who lives in the home with you to provide Personal Assistance, Supportive Home Care, or Respite.

You can decide if you want to join Consumer Direction or use providers contracted with Amerigroup to give your services. You can change your mind anytime.

If you enroll in ECF CHOICES and decide **<u>not</u>** to join Consumer Direction, you will get the services you need from providers contracted with Amerigroup.

Paying for your services in Employment and Community First CHOICES

You may have to pay part of the cost of the services you get in Employment and Community First CHOICES. It's called **"patient liability."** The amount you pay depends on your income. You will only have patient liability if you had to set up a **Q**ualifying **I**ncome **T**rust (**QIT**) to qualify for Medicaid. Sometimes a QIT is called a Miller trust. If you owe patient liability, you **must** pay your patient liability in Employment and Community First CHOICES.

You'll pay your patient liability to your health plan, unless you get Community Living Supports. Your health plan will tell you how much you owe and how to pay.

What if you DON'T pay the patient liability you owe? 4 things could happen:

1. Your providers could decide not to give you services in Employment and Community First CHOICES anymore.
2. And if you won't pay your patient liability, Amerigroup could decide not to provide your services in Employment and Community First CHOICES anymore. They can't meet your needs if they can't find any providers willing to give you services. They must send you a letter that says why they can't provide these services anymore. If you think they're wrong, you can appeal. Their letter will say how to appeal.
3. And if you won't pay your patient liability, other TennCare health plans may not be willing to provide your services in Employment and Community First CHOICES. If that happens, you may not be able to stay in Employment and Community First CHOICES. If you can't stay in Employment and Community First CHOICES, TennCare will send you a letter that says why. If you think we're wrong, you can appeal. That letter will say how to appeal.
4. And if you can't stay in Employment and Community First CHOICES, you may not qualify for TennCare anymore. If the only way you qualify for TennCare is because you get services in Employment and Community First CHOICES, you could lose your TennCare too. Before your TennCare ends, you will get a letter that says how to appeal if you think we're wrong.

Do you have medical bills for care you got <u>before</u> your TennCare started? This includes care in a nursing home, or Medicare co-pays or deductibles.

Or, do you have medical bills for care you got <u>after</u> TennCare started that TennCare doesn't cover? This includes eye glasses, hearing aids, and dental care for adults.

We may be able to subtract those bills from the patient liability you owe each month. This means your patient liability will be less. (It can even be zero.) We'll keep subtracting those bills until the total cost of your medical bills has been subtracted.

The bills must be for care you got in the 3 months before the month you applied to TennCare. For example, if you apply for TennCare in April, the bills must be for January, February and March.

These can be bills you've already paid. Or they can be bills you haven't paid yet. But you must be expected to pay them. (You don't have other insurance to pay for them.) What if a family member or someone else paid these bills? Send them only if they expect you to pay them back.

If you have medical bills like this, send them to TennCare. There are 2 ways to get them to us.

By mail:	Tennessee Health Connection P.O. Box 305240 Nashville, TN 37230-5240
By fax:	1-855-315-0669

On each page you send, be sure to write "for patient liability" and include your name and Social Security number.

Do you have Medicare or other insurance that helps pay for long-term care? If you do, that insurance must pay **first.** TennCare can't pay for care that's covered by Medicare or other insurance.

Do you have long-term care insurance that pays **you?** Then you must pay the amount you get to help cover the cost of your services in Employment and Community First CHOICES. This **won't** lower the amount of any patient liability you owe. You must pay any long-term care insurance you get **and** any patient liability you owe.

For more information about Employment Community First CHOICES benefits and services see Appendix A.

Paying TennCare back for the services you get in Long-Term Services and Supports: Estate Recovery

What is Estate Recovery and what does it mean for you?

Your **"estate"** is made up of the things you own that you leave behind when you die. It includes your money, your home, other property, or other things you own.

Estate recovery is using the value of things you leave behind when you die to pay TennCare back for care you received while you were living.

<u>Why</u> you have to pay TennCare back for your care

TennCare services are paid for by the State and federal government. If TennCare pays for certain kinds of care, TennCare is required by federal law to try to get paid back for that care after your death.

<u>Who</u> has to pay TennCare back for their care

TennCare **must** ask to be repaid for money it spent on your care if you are:

- Any age and got nursing home care if you weren't expected to return home (this includes care in an intermediate care facility for individuals with intellectual disabilities or ICF/IID)
- Or age 55 and older and got care in a nursing home or ICF/IID, home care — called home and community based services or HCBS, home health or private duty nursing

<u>What kinds</u> of care must be paid back to TennCare

TennCare **must** ask to be repaid for:

- Care in a nursing home or ICF/IID
- Home care or HCBS (as well as home health or private duty nursing)
- Hospital care and prescription drugs you got while you're getting long-term services and supports

TennCare can also ask to be paid back for the cost of **any other care** we paid for.

<u>How much</u> your estate will have to pay TennCare back for your care

TennCare is a managed care program. This means that TennCare contracts with health plans to provide the services you need. This includes health and mental health services and some long-term services and supports (like care in a nursing home or some kinds of home care).

TennCare pays your health plan a monthly payment for care they are contracted to provide. The payment is based on the kinds of services you are expected to receive from your health plan. It takes into account things like your age, if you have a disability, and if you receive long-term services and supports. Part of that payment is for the kinds of care that must be paid back to TennCare.

The payment made to your health plan is the same each month, no matter what services you actually receive that month. The monthly payment to a health plan may exceed $5,000 per month for people who receive long-term services and supports. It can also vary depending on which health plan you have and the part of the state you live in.

Federal rules say that the amount of money TennCare must be paid back for care you got from your health plan is the amount TennCare paid your health plan for those services. This may be different than the cost of services you actually received.

A few services are not part of managed care. They include care in an ICF/IID or home care for people with intellectual disabilities through an HCBS waiver program operated by the Department of Intellectual and Developmental Disabilities. But TennCare still has to be paid back for that care too.

TennCare can't ask for the money back until **after** your death. TennCare can't ask for more money back than we paid for your care. (This includes payments to your health plan and the actual cost of services that aren't part of managed care.) And TennCare can't ask your family to pay for your care out of their own pockets.

TennCare may not have to get the money back from your estate if:

- You leave very little money or property when you die
- Your care did not cost much

- The things you left can't be used to pay people you owe through probate court. An example is life insurance money.

But these times do not happen by themselves. The person handling your things after you die **must get a "Release" from TennCare**. It says you don't owe TennCare money. If your things have to go through Probate court, the Release must be filed there.

Sometimes TennCare must let your money or property stay in the family longer.

These times are if you leave your money or property to:
- Your surviving husband or wife
- Your child who is under age 21 when you die
- Or your child of any age who is blind or permanently and totally disabled.

TennCare won't try to get repaid until this family member dies or the child turns age 21. But the person who handles your things **must** file the TennCare Release in Probate Court.

Sometimes TennCare must let just your HOME stay in the family longer.

This happens when one of these family members lives in the home when you die:
- Your surviving husband or wife
- Your child who is under age 21 when you die
- Your child of any age who is blind or permanently and totally disabled
- Your child who lived in the home and took care of you if this care kept you out of a nursing home or home care for 2 years
- Or your brother or sister who helped make the house payments if they lived there for a year before you got nursing home or home care.

By law, TennCare should not take the house until these family members die or the child turns 21. But the person who handles your things **must** file the TennCare Release in Probate Court.

TennCare may leave your money and property in the family because of undue hardship.

But the State does not do this very often. The family must prove that losing the money or property in your estate will cause an undue hardship. For example, if your property is a family farm and the family's only income, then the person handling your things can ask the State not to take the property. The State may or may not agree.

How will your family find out if your estate owes money to TennCare?

After you die, the law says that your estate must be used first to pay the debts you owe. What's left after your debts are paid is given to the people who should have it. This is called "probate." Your debts include any amount you must pay TennCare for care you received while you were living. The probate court cannot close your estate until your lawyer or executor of your estate gets a Release from TennCare. A Release says your estate doesn't owe TennCare any money.

To get a Release, the person must complete a Request for Release Form and send it to TennCare. It must include all of the proof that's asked for. TennCare will send a Release if:
- Your estate doesn't owe TennCare any money,

- OR, if you don't have to pay TennCare any money from your estate right now.

What if you do have to pay TennCare money from your estate? TennCare will file a claim against your estate. It will say the amount your estate must pay TennCare for care you received. That money must be paid by your estate **before** TennCare will provide a Release.

How to ask for a Release from TennCare

The person handling your things after you die may apply for a Release in one of three ways:

1. Get the Release online at https://tn.gov/assets/entities/tenncare/attachments/releaseform.pdf.

2. Get the Release from the Probate Court Clerk's office by asking for a "Request for Release from Estate Recovery."

3. Get the Release from TennCare by sending a letter or fax to:

   Division of TennCare
   Estate Recovery Unit
   310 Great Circle Road
   Nashville, TN 37243
   FAX: (615) 413-1941

All of the information asked for in the Release must be included. And they must provide any other information TennCare requests to decide if the Release will be given.

Do you have questions or need help with estate recovery?

- You can **call** TennCare for free at 1-866-389-8444.
- OR, you can **fax** TennCare at (615) 413-1941.
- OR, you can **mail** TennCare at:

  Division of TennCare
  Estate Recovery Unit
  310 Great Circle Road
  Nashville, TN 37243

Abuse, Neglect and Exploitation

TennCare members in Employment and Community First CHOICES have the right to be free from abuse, neglect and exploitation. It's important that you understand **how to identify** and **how to report** abuse, neglect and exploitation.

Abuse can be…
- Physical abuse;
- Sexual abuse; or
- Emotional or psychological abuse.

It includes injury, unreasonable confinement, intimidation, or punishment that results in physical harm, pain or mental anguish.

Abuse of all forms is a "knowing" or "willful" act.

Neglect is the failure to provide services and supports that are necessary to avoid physical harm, mental anguish or mental illness and that results in injury or probable risk of serious harm. Neglect may or may not be intended.

Exploitation means that someone's money or belongings are intentionally taken, misplaced or misused. Even if they are only taken for a short time or the person gave their consent, it may still be exploitation.

Exploitation can include…

- Fraud or coercion;
- Forgery; or
- Unauthorized use of cash, bank accounts or credit cards.

If you think you're a victim of abuse, neglect or exploitation or that any other ECF CHOICES member is a victim of abuse, neglect or exploitation, please tell your Support Coordinator. Support Coordinators and providers must report any suspected case of abuse, neglect or exploitation to the Department of Intellectual and Developmental Disabilities (DIDD).

You, your family, people who support you or any private citizen may report suspected abuse, neglect or exploitation directly to the DIDD Investigations Unit 24 hours a day.

The number to call depends on where you live. The toll free numbers for each region are:

East Tennessee	**1-800-579-0023**
Middle Tennessee	**1-888-633-1313**
West Tennessee	**1-888-632-4490**

You don't have to tell them who you are when you report. DIDD will work with law enforcement as needed, and with Adult Protective Services and Child Protective Services.

Do you have a **mental illness and need help with this information?** The TennCare Partners Advocacy Line can help you. Call them for free at **1-800-758-1638**.

If you have a hearing or speech problem, you can call us on a TTY/TDD machine. Our **TRS** number is **711**.

Part 4: How the TennCare Program works for you

What you pay for your health care

Your Co-pays

Preventive care is care that helps you stay well, like checkups, shots, pregnancy care, and childbirth. This kind of care is always free. You don't have co-pays for preventive care. More information about preventive care is in Part 2.

For other care like hospital stays or sick child visits, you **may** have to pay part of the cost. Co-pays are what you pay for each health care service you get.

Not everyone on TennCare has co-pays. Your Amerigroup card will tell you if you have co-pays and what they are. Co-pays depend on:

- the kind of TennCare that you have (TennCare Medicaid or TennCare Standard), and
- sometimes on your family's monthly income before taxes, and
- how many people in your family live with you.

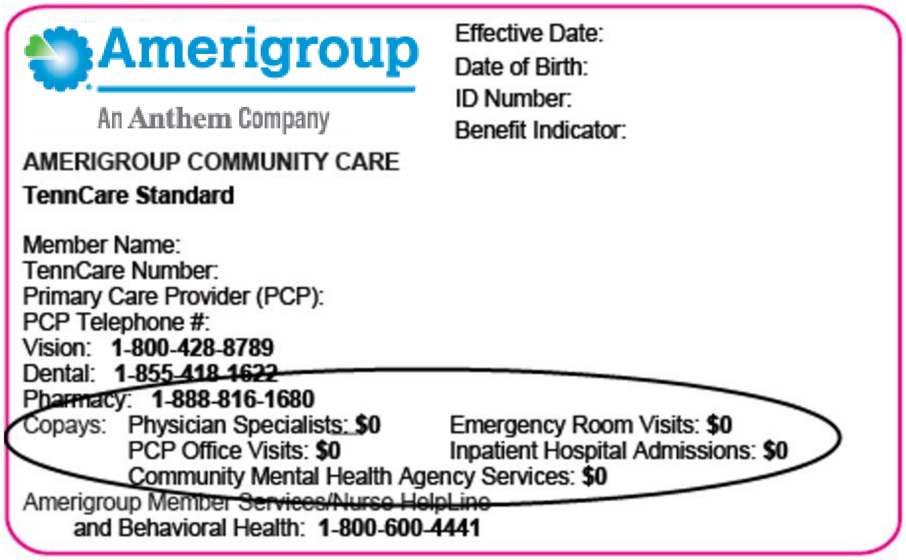
Do you have other insurance that pays for your health care? Because you also have TennCare, you **only** pay the TennCare co-pay. Later in this handbook you'll learn more about how TennCare works with other insurance.

Pregnant women **do not** have co-pays for medicine they get while they are pregnant. People getting hospice care **do not** have co-pays for prescription medicines they get for hospice care. If you are pregnant or you are getting hospice care, **you must tell** the pharmacist so you will **not** be charged your co-pay.

You should only have to pay your co-pay for your care. You should **not** be billed for the rest of the cost of your care. If you are billed for the rest of the cost, you can appeal. See Part 5 of this handbook to find out what to do if you get a bill for your care.

None of the doctors or health care providers in Amerigroup can **refuse** to give you medically necessary services because you don't pay your co-pays. But, Amerigroup and your providers can take steps to collect any co-pays you owe.

Your health plan cards tell you if you have co-pays.



Your Amerigroup card tells you if you have co-pays for doctors, specialists, hospital and ER visits.

Your TennCare Pharmacy Plan card tells you if you have co-pays for prescription medicines.

The following pages tell you more about TennCare co-pays and where to call if you have questions.

TennCare Co-pays

Do you pay co-pays for a PCP, Specialist, ER visit, and hospital stay? Not sure? Check your Amerigroup card or call the Tennessee Health Connection at 1-855-259-0701.

Member	Prescription co-pay	PCP (general doctor) co-pay	Specialist co-pay	Emergency Room Use (if not admitted)	Hospital Stay co-pay
TennCare Medicaid **children** under 21	none	none	none	none	none
TennCare Standard **children** under 21, below 100% federal poverty level*	none	none	none	none	none
TennCare Standard **children** under age 21, from 100% to 199% federal poverty level*	$3 co-pay for Brand names; $1.50 co-pay for generics	$5	$5	$10	$5
TennCare Standard **children** under age 21, at 200% and above federal poverty level*	$3 for Brand names; $1.50 co-pay for generics	$15	$20	$50	$100
TennCare Medicaid **adults** 21 and older, who get long-term care that TennCare pays for	none	none	none	none	none
TennCare **adults** 21 and older, who are in CHOICES Group 3	$3 for Brand names; $1.50 co-pay for generics	none	none	none	none
TennCare Medicaid **adults** 21 and older, who **DO NOT** get long-term care that TennCare pays for	$3 for Brand names; $1.50 co-pay for generics	none	none	none	none

*To find out what percent of the federal poverty level (FPL) your household is, look at the income amounts online at:
https://www.tn.gov/content/dam/tn/tenncare/documents/eligibilityrefguide.pdf

Do you have TennCare Medicaid? You can go to page 74.

The next page is only important for members who have TennCare Standard.

Do you have TennCare Standard? To find out what you must pay in co-pays for health care, look at your Amerigroup card or call the Tennessee Health Connection at the phone numbers above.

If you have TennCare Standard, you will have a limit on the total amount of co-pays you will pay each quarter (every three months). You should have gotten a letter from TennCare that said how much your limit would be. The co-pays you pay for each child on TennCare Standard will be combined to help you reach your limit each quarter.

Here's how TennCare counts the quarters in one year:

- 1st quarter - January, February, and March
- 2nd quarter - April, May, and June
- 3rd quarter - July, August, and September
- 4th quarter - October, November, and December

Your family's co-pay **limit** every 3 months is based on the income you report to TennCare. This limit is the **most** you will pay in co-pays each quarter.

Be sure to keep the receipts showing what you were charged in co-pays during the quarter. Keep them together in a safe place because you will need them later. **Why?** If you reach your out of pocket maximum in one quarter, you won't pay any more co-pays for that quarter. But you must tell TennCare when you've reached your limit for the quarter.

As soon as your receipts total your limit during one quarter, call the TennCare Solutions Unit for free at **1-800-878-3192**. Tell them you've reached your family's co-pay limit. They will ask you to send them copies of your receipts showing your total.

Each receipt must show:

- The kind of care you got,
- the name of the **person** who got the care,
- the name of the **doctor or other place** that gave you the care,
- the **date** you got the care, **and**
- the **amount** you were charged for the care.

Important! A cash register receipt, Explanation of Benefits (EOB), or credit card receipt may not show everything we need.

After TennCare reviews your receipts, you'll get a letter that says you've met your limit for that quarter. Once you get that letter, you won't have to pay any more co-pays for that quarter. When the new quarter starts, you'll pay your co-pays again.

What if your receipts for the quarter total more than your limit? Call the TennCare Solutions Unit at **1-800-878-3192**. Tell them you've met your family's co-pay limit.

If your income changes or your family size changes, your co-pays might change, too. You must report any changes in family size or income to TennCare by calling the Tennessee Health Connection as soon as possible.

Do you have questions about co-pays or your quarterly limit? The Tennessee Health Connection can answer those questions too. Call them for free at **1-855-259-0701**.

How TennCare works with other insurance and Medicare

If you have other insurance, your TennCare works in a different way.

TennCare and other insurance

We discussed in Part 1 the difference between TennCare Medicaid and TennCare Standard. The kind of benefits you have, whether you must pay a co-pay, and whether you can have other insurance and still qualify for TennCare all depend on the kind of TennCare you have. In this section, we're going to discuss how TennCare works with other insurance.

*Do you have Medicare? The next page tells you how TennCare works with Medicare.

TennCare Medicaid and other insurance:

Most people who have TennCare Medicaid **can** have other health insurance. This is how your TennCare Medicaid works if you have other insurance.

- Your other **health insurance must pay first**, before your TennCare. This is called your "primary insurance."
- Your TennCare pays for covered services that your other health insurance does not cover. For example, if your other health insurance covers prescription medicines, you cannot use your TennCare for prescriptions.

If you have other health insurance, you must tell:

- the **place** where you are getting health care so that they can bill the right insurance.
- the Tennessee Health Connection so that TennCare knows about your other health insurance.

What if you get a bill for services that you think you should not have to pay? If you have other insurance besides TennCare, it could be because your different health insurance companies are not being billed correctly. Call us at **1-800-600-4441** for help.

Co-pays
If your primary insurance pays first for a TennCare covered service, you should only pay your TennCare co-pay.

For example: your primary insurance has a $25 co-pay for a PCP office visit. But, you have TennCare Medicaid, and there is no TennCare co-pay for a PCP. What happens then? Your PCP should not charge you the co-pay but should file the claim for your visit with your primary insurance.

TennCare Standard and other insurance:

Most people who have TennCare Standard **can't** have other insurance or have "access" to group health insurance. **"Access to group health insurance"** means that you can get health insurance through an employer or some other group health plan. For TennCare Standard, it doesn't matter how much the other insurance costs, or what services it covers. What matters is if the other insurance has been offered to you, or is available to you.

Remember, TennCare Standard is for children who are under age 19 who are losing their TennCare Medicaid. When it was time to see if they could keep TennCare Medicaid, they weren't eligible. But, the TennCare Standard rules say that these children can move to TennCare Standard if they don't have access to group health insurance.

Having access to other insurance, even Medicare, is not allowed for children who have TennCare Standard.

Have you been in an accident?
Sometimes when you are in an accident, there is someone else who should pay for your health care. This could be a car accident or an accident at work. You must let us know who should pay for your health care if you are in an accident. Call us for free at **1-800-600-4441**.

TennCare and Medicare

Medicare is counted the same as group health insurance. It is for people who are age 65 and older, and for some people of any age who Social Security says are disabled. People with end stage renal disease can have Medicare too.

These are the different parts of Medicare:
Part A is for hospital stays, skilled nursing facility care, home health care, and hospice care.
Part B is for your doctor's services and outpatient care.
Part D is for prescription medicines.

There are also other ways to have Medicare. These are called **Medicare Health Plans (these plans are sometimes called Medicare Part C).** These plans put all of the parts A, B, and D together for you in one plan.

Medicare charges you for premiums, deductibles, and co-pays. If you can't pay for these, you can apply for a program called **QMB.** QMB (Qualified Medicare Beneficiary) pays for:
- Your Medicare premiums.
- The hospital deductible that Medicare doesn't pay.
- The part of each doctor bill that Medicare doesn't pay.

You apply for QMB by calling the Tennessee Health Connection at 1-855-259-0701.

If you have Medicare and get SSI, you already have QMB. You don't need to apply.

To learn more about **Medicare**, call them at **1-800-633-4227**. It's a free call.

Another place that can help you with Medicare is called SHIP (State Health Insurance Assistance Program). To get help with Medicare, you can call **SHIP** for free at **1-877-801-0044**.

If you have TennCare and Medicare, your TennCare works in a different way.
- Your **Medicare is your first (primary) insurance.** Hospitals, doctors and other health care providers will bill Medicare first.
- Your **TennCare is your second (secondary) insurance.** After your providers bill Medicare, they will also bill TennCare for your Medicare co-pays and deductibles. **Remember,** TennCare **won't pay at all** for prescriptions when adults have Medicare. Are you under age 21 with Medicare? Keep reading to find out when TennCare pays for your prescriptions.
- Do you have TennCare Medicaid because you are enrolled in the Breast and/or Cervical Cancer (BCC) Program? Then you **can't also** have Medicare. If you become eligible for

Medicare while you are enrolled in the BCC program, TennCare will send you a letter. It will say they must see if you're eligible for TennCare Medicaid another way.

- If you need health care that's not covered by Medicare but is covered by TennCare, go to an Amerigroup provider for those TennCare covered services, so that TennCare will pay for them.
- For Medicare adults age 21 or older, TennCare **does not** pay for prescription medicines. Medicare Part D pays for your prescription medicines.
- For children under age 21 who have both TennCare and Medicare:
    - Medicare Part D pays for most of your prescription medicines. TennCare **does not** pay the co-pay for your Medicare prescriptions.
    - And, TennCare will pay for only those TennCare covered medicines that Medicare does not cover.

Part 5: Help for problems with your health care or TennCare

Kinds of problems and what you can do

You can have different kinds of problems with your health care.

You can fix some problems just by making a phone call. If you have complaints or problems about your health care, call us at **1-800-600-4441** for help.

Some problems may take more work to fix. Here are some examples of different kinds of problems and ways that you can fix them.

Need a new TennCare card?

If your card is lost or stolen, or if the information on your card is wrong, you can get a new one.

- For a new Amerigroup card, call **1-800-600-4441**.
- For a new Prescription Card, call TennCare's pharmacy help desk at **1-888-816-1680**.

You don't have to wait for your new card to get your care or medicine. Tell your doctor or the drug store that you have TennCare.

Need to find a doctor or change your doctor?

You can learn how to find a new doctor in Part 1 of this handbook.

Are you changing because you are unhappy with the doctor you have? Please tell us. Call us at **1-800-600-4441**. We want to make sure that you get good care.

Need to make a complaint about your care?

If you are not happy with the care that you are getting, call us at **1-800-600-4441**. Tell us that you need to make a complaint.

No one can do anything bad to you if you make a complaint. We want to help you get good care.

Need help with a ride to your health care appointment?

If you don't have a way to get to your health care visits, you may be able to get a ride from TennCare. Do you need help with a ride? Are you having problems setting up your ride or getting to your appointment on time? Call us at **1-800-600-4441** to tell us you need help.

Need to change your health plan?

- If you want to change health plans because you're having problems getting health care, tell us. Call us at **1-800-600-4441**. We'll help you fix the problem. You **don't** have to change health plans to get the care you need.
- Do you want to change health plans so you can see a doctor that takes that plan?
- **Remember!** You must make sure that all of your doctors take your new health plan. You'll only be able to see doctors that take your new plan.
- What if you have an OK from your health plan for care you haven't gotten? If you change plans and still need the care, you'll have to get a new OK from your new plan.

Check these things before you decide to change health plans:

1. Does the doctor take the health plan you want to change to?
2. Is the health plan you want to change to taking new TennCare members?

There are two times when it's easy to change your health plan.

1. When you first get TennCare, you have **45 days** to change your health plan. When you get TennCare, they send you a letter. That letter says how to change your health plan within the first 45 days.
2. Once a year during your "open enrollment month." **When** you can change depends on where you live.

Find Your County Below:

➢ **Do you live in one of these West TN counties?** Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, Madison, McNairy, Obion, Shelby, Tipton, or Weakley.

If so, you can change your health plan during the month of **March.** Your new health plan assignment would begin May 1. Until then, we would continue to provide your care.

➢ **Do you live in one of these Middle TN counties?** Bedford, Cannon, Cheatham, Clay, Coffee, Cumberland, Davidson, DeKalb, Dickson, Fentress, Giles, Hickman, Houston, Humphreys, Jackson, Lawrence, Lewis, Lincoln, Macon, Marshall, Maury, Montgomery, Moore, Overton, Perry, Pickett, Putnam, Robertson, Rutherford, Smith, Stewart, Sumner, Trousdale, Van Buren, Warren, Wayne, White, Williamson, or Wilson.

If so, you can change your health plan during the month of **May**. Your new health plan assignment would begin July 1. Until then, we would continue to provide your care.

➢ **Do you live in one of these East TN counties?** Anderson, Bledsoe, Blount, Bradley, Campbell, Carter, Claiborne, Cocke, Franklin, Grainger, Greene, Grundy, Hamblen, Hamilton, Hancock, Hawkins, Jefferson, Johnson, Knox, Loudon, Marion, McMinn, Meigs, Monroe, Morgan, Polk, Rhea, Roane, Scott, Sequatchie, Sevier, Sullivan, Unicoi, Union, or Washington .

If so, you can change your health plan **only** during the month of **July**. Your new health plan assignment would begin September 1. Until then, we would continue to provide your care.

Important! You have until the **last day** of your open enrollment month to ask to change your health plan.

Other reasons that you can ask to change your health plan are if:

- You have family members in the health plan you want to change to
- **Or**, TennCare made a mistake by giving you a health plan that doesn't do business in the area where you live
- **Or**, you moved and your health plan doesn't do business in the area where you now live.

You may be able to change your health plan if you have a hardship reason to change. But to meet hardship, all of these things must be true for you:

1. You have a medical condition that requires difficult, extensive, and ongoing care, and
2. Your specialist no longer takes your health plan, and
3. Your health plan doesn't have a specialist that can give you the care that you need, and
4. Your health plan can't work with your specialist to get you the care that you need, and
5. Your specialist takes the health plan you want to change to, and
6. The health plan you want to change to is taking new TennCare members.

A **specialist is a doctor who gives care for a certain illness or part of the body. One kind of specialist is a cardiologist who is a doctor that treats you for heart problems. Another is an oncologist who is a doctor that treats you for cancer. There are many different kinds of specialists.

To Ask To Change Your Health Plan, you must tell TennCare:

- Your **Social Security number.** If you don't have that number, give your date of birth. Include the month, day and year.
- The name of **the health plan you want.**
- And, the **reason you want to change health plans.**

Call the TennCare Solutions Unit (TSU) at **1-800-878-3192.** Tell them you want to change your health plan.

Or you can write to them on plain paper. If you write to the TennCare Solutions Unit (TSU), make sure you tell them:

- Your name (first, middle initial and last name)
- Your Social Security number
- The name of the health plan listed above that you want to change to
- The name and Social Security number of anyone else in your family that also needs to change to this health plan
- Your daytime phone number and the best time to call.

Then mail your request to:

TennCare Solutions
P.O. Box 820
Nashville, TN 37202-9968

Or, you can fax your request to **1-866-581-5735**.

Need help getting prescription medicine?

Part 2 of this handbook tells you how TennCare works for prescription medicines.

Do you need a doctor to prescribe your medicine for you?
What if you need to find a doctor, or your doctor won't prescribe the medicine you need? Call us at **1-800-600-4441**.

Do you need an OK from TennCare to get your medicine? It's called a "prior authorization" or PA.
If your medicine needs an OK, call your doctor. Ask your doctor to:

- Call the TennCare Pharmacy Program to get TennCare's OK for this medicine.
- Or, change your prescription to one that doesn't need an OK.

What if your doctor doesn't ask for TennCare's OK or change your prescription?
Then, you can ask TennCare to OK your medicine. Call **1-800-639-9156**.

What if your doctor asks for an OK and TennCare says no?
You can ask your doctor to prescribe a different medicine that doesn't need an OK.

Or, if you think TennCare made a mistake, you can appeal. You have 60 days after TennCare says **no** to appeal. For more information on how to appeal see Part 6 of this handbook.

Did you get a letter that said you asked TennCare to pay for more than 5 prescriptions or more than 2 brand name medicines this month?

- Call your doctor to see if you need **all** the medicine you're taking.
  What if he says you do? Then you may want to ask your doctor to help you pick the medicines that are most important.

  Or, you can ask your drug store to help you pick the medicines that cost most. Each month, get those filled **first** so TennCare will pay for them.

- You can ask the drug store or your doctor if your medicine is on the **Exempt List**. (That's TennCare's list of medicines that won't count against your prescription limit.)
  Even if you've gotten **5** prescriptions or **2** brand name medicines in 1 month, you **can** still get medicines on that list.

- If you asked TennCare to pay for too many **brand name medicines**, ask your doctor to **prescribe generic medicines.**

- You can also talk to your doctor about the **Over-the-Limit (or Attestation) List.** After you've reached your monthly limit (of 5 prescriptions or **2** brand name drugs), your doctor can get TennCare's **OK** to pay for drugs on this list. (Drug stores may call it the **"**Prescriber Attestation**"** list.)

For more information on the Exempt List and the Over-the-Limit List, see Part 2 and Part 5 of this handbook. To get a current list of both, go to: http://www.tn.gov/tenncare/mem-pharmacy.shtml.

Or, if you think TennCare made a mistake counting your prescriptions this month, you can appeal. In your appeal, tell TennCare:

1. Your **Social Security number.** If you don't have that number, give your date of birth. Include the month, day and year.
2. The **kind of medicine** you are appealing about
3. And the **reason you want to appeal – that you think TennCare made a mistake counting your prescriptions this month.** Tell us as much about the problem as you can.

Be sure you include any mistake you think TennCare made. Send copies of any papers that you think may help us understand your problem. You can appeal by mail, fax, or telephone. For more information on how to file an appeal, see Part 6 of this handbook.

Did the drug store say you don't have TennCare prescription coverage anymore?
There are two ways this might happen:

1. For adults who have Medicare **and** TennCare, TennCare doesn't pay for prescriptions anymore. You must get your medicine through Medicare Part D. For help with Medicare Part D, call your Part D plan. Or, you can call **Medicare** at **1-800-633-4227**. Sometimes your drug store can help you with Medicare Part D, too.

2. If you are an adult on TennCare Standard, your TennCare doesn't pay for prescriptions for you. To see if you can get other help with your medicine, call Cover RX at **1-866-268-3786**.

Did the drug store say that they can't fill your prescriptions because you don't have TennCare? Before your TennCare ends, you will get a letter in the mail. The letter will say why your TennCare is ending. It will also say how to appeal. But, if you move and don't tell TennCare, you may not get the letter. You may not find out that your TennCare ended until you go to the drug store.

Do you think TennCare made a mistake? Call the **Tennessee Health Connection** at **1-855-259-0701**. They can tell you if you have TennCare, or if it ended. If you think TennCare made a mistake, they can tell you if you still have time to appeal.

Need help getting your health care services?

Part 2 of this handbook tells you about the health care services that TennCare pays for.

For problems about physical and/or behavioral health (mental health, alcohol or drug abuse) care, always call us at **1-800-600-4441** first.

If you still can't get the care you need, you can call **TennCare Solutions** at **1-800-878-3192**. Call Monday through Friday from 8 a.m. until 4:30 p.m. Central time. But if you have an emergency, you can call anytime.

Do you need an OK before TennCare will pay for your health care? It's called a "prior authorization" or PA. If your care needs an OK, call your doctor. Your doctor has to ask us for an OK.

Did we say no when your doctor asked for an OK for your care?
Call your doctor and/or behavioral health (mental health, alcohol or drug abuse) provider and tell him or her that we said no.

If you or your doctor thinks we made a mistake, you can appeal. You have 60 days after your health plan says **no** to appeal. For information on Appeals, go to Part 6 of this handbook.

Did you pay for health care that you think TennCare should pay for? Or, are you getting billed for health care that you think TennCare should pay for? Sometimes you might get a bill if the doctor doesn't know that you have TennCare. Every time you get care, you **must:**

- Tell the doctor or other place you get care that you have TennCare.
- **Show** them your TennCare card.

If you've gotten health care that you think TennCare should pay for, call us at **1-800-600-4441**. If you're getting bills for the care, we can help you find out why. If you paid for the care, we'll see if we can pay you back.

Or you can appeal. If you're getting bills, you have 60 days from when you get your first bill to appeal. If you paid for the care, you have 60 days after you pay to appeal.

For information on Appeals, go to Part 6 of this handbook.

Ways that your TennCare could end

You can ask to end your TennCare. There are 2 ways to ask to end your TennCare:

1. **Call** the Tennessee Health Connection free at **1-855-259-0701** and let them know you want to end your TennCare.
2. **Send a letter** to the Tennessee Health Connection that says you want to end your TennCare. Include your name, Social Security number and make sure you **sign** the letter.

Important! If you don't **sign your letter** it will delay your request. You may have to send in another request with your signature.

Do you want to end TennCare for other family members? Put their names and Social Security numbers in the letter too.

Send your letter to: Tennessee Health Connection
P.O. Box 305240
Nashville, TN 37230-5240

Or fax it to: **1-855-315-0669**

Other ways that your TennCare can end:

- If something changes for you and you don't meet the rules for TennCare anymore.
- If you let someone else use your TennCare card.
- If you don't follow the rules of Amerigroup or TennCare, more than once.
- If you don't fill out redetermination papers for your TennCare when you are asked to. TennCare members must renew their TennCare each year. When it's time to see if you still qualify for TennCare, TennCare will send you a letter and redetermination pages in the mail.

Before your TennCare ends, you will get a letter in the mail. The letter will tell you why your TennCare is ending. It also tells you how to file an appeal if you think they've made a mistake.

Do you need more help with health care? Or do you need more help with mental health care or drug or alcohol treatment? Or help with other TennCare problems?

Call the **TennCare Advocacy Program.** Call them for free at **1-800-758-1638.**

Part 6: TennCare Appeals

If you are having problems with your health care or TennCare, you have the right to file an appeal.

An appeal is one way to fix mistakes in TennCare. When you appeal, you're asking to tell a judge the mistake you think TennCare made. It's called a **fair hearing**.

Your right to appeal and right to a fair hearing are explained more in Part 7 of this handbook.

There are 2 different kinds of appeals: Administrative Appeals and Medical Appeals.

Administrative Appeals are for problems like getting or keeping TennCare, disagreeing with the kind of TennCare you have, or if you think your income or co-pay amounts are wrong. Administrative appeals goes to the Eligibility Appeals Unit at the Tennessee Health Connection. Page 86 tells you more about filing an administrative appeal.

Medical Appeals are for problems with your health care. For problems with health care, always call us **at 1-800-600-4441** first.

If you **still** can't get the care you need, you can file a medical appeal.

Medical Appeals

You have 60 days after you find out there's a problem to appeal.

- For care or medicine you still need, you have **60 days** after TennCare or Amerigroup says we won't pay for the care.
- For health care bills you think TennCare should pay, you have **60 days** after you get your first bill.
- For care you paid for, you have **60 days** after you pay for the care.

Keeping Your Care During Your Appeal (Continuation of Benefits)

If you are already getting care, you may be able to keep getting it during your appeal. To keep getting care during your appeal, **all** of these things must be true:

1. You must appeal by the date your care will stop or change or within 10 days of the date on the letter from your health plan (whichever date is later).
2. You must say in your appeal that you want to keep getting the care during the appeal.
3. The appeal must be for the **kind** and **amount** of care you've been getting that has been stopped or changed.
4. You must have a doctor's order for the care (if one is needed).
5. The care must be something that TennCare still covers.

Important! What if you want to keep getting care **during** your appeal and you lose your appeal? You may have to pay TennCare back for the care you got during your appeal.

Do you think you have an emergency?
Usually, your appeal is decided within **90 days** after you file it. But, if you have an emergency and your health plan agrees that you do, you will get an **expedited** appeal. An expedited appeal

will be decided in about one week. It could take longer if your health plan needs more time to get your medical records.

An emergency means waiting 90 days for a “yes” or “no” decision **could put your life or physical or mental health in real danger.**

If one of those things is true for you, you can ask TennCare for an emergency appeal. Your **doctor** can also ask for this kind of appeal for you. But the law requires your doctor to have **your permission (OK) in writing.** Write **your name, your date of birth, your doctor’s name, and your permission for them to appeal for you** on a piece of paper. Then fax or mail it to TennCare (see **below**).

What if you don’t send TennCare your OK and your doctor asks for an expedited appeal? TennCare will send you a page to fill out, sign and send back to us.

After you give your OK in writing your doctor can help by completing a Provider’s Expedited Appeal Certificate like the one in Part 8 of this handbook. If your appeal is an emergency, you can have your doctor sign the Provider’s Expedited Appeal Certificate. Your doctor should fax the certificate to 1-866-211-7228.

TennCare and your health plan will then look at your appeal and decide if it should be expedited. **If it should be**, you will get a decision on your appeal in about one week. Remember, it could take a few more days if your health plan needs more time to get your medical records. But, if your health plan decides your appeal should not be expedited, then you will get a hearing within 90 days from the date you filed your appeal.

How to file a Medical Appeal

There are 2 ways to file a medical appeal:

1. Call. You can call TennCare Solutions for free at **1-800-878-3192**.
We’re here to help you Monday through Friday from 8 a.m. until 4:30 p.m. Central time.

2. Or, appeal **in writing.** You can use the medical appeal page in Part 8 of this handbook. If you give your OK, someone else like a friend or your doctor can fill the page out. To print an appeal page off the Internet, go to: http://www.tn.gov/assets/entities/tenncare/attachments/medappeal.pdf. If you need another medical appeal page or want TennCare to send you one, call **TennCare Solutions** at **1-800-878-3192.** Or, you can write your appeal on plain paper.

There are 2 ways you can file a medical appeal in writing. Pick one of the choices below:

1. Mail. You can mail an appeal page **or** a letter about your problem to:

TennCare Solutions
P.O. Box 000593
Nashville, TN 37202-0593

Keep a copy of your appeal. Write down the date that you mailed it to TennCare.

2. Or Fax. You can fax your appeal page or letter for free to **1-888-345-5575**.
Keep the paper that shows your fax went through.

For all medical appeals, TennCare needs:

- Your **name** (the name of the person who wants to appeal about their care or medicine).

- Your **Social Security number.** If you don't have the SSN number, give your date of birth. Include the month, day and year.
- The **address** where you get your mail.
- The **name** of the person to call if TennCare has a question about your appeal (this can be you, or someone else).
- A **daytime phone number** for that person (this can be your phone number, or another person's phone number).

What else does TennCare need to work your appeal?

To get a fair hearing about health care problems**, you must do both of these things:**

- You must give TennCare **the facts** they need to work your appeal.
- And, you must tell TennCare the **mistake** you think we made. It must be something that, if you're right, means that TennCare will pay for this care.

Depending on the reason you are filing a medical appeal, here are some other kinds of information you must tell TennCare:

Are you appealing about **care or medicine you still need?** Tell TennCare:

- The **kind of health care or medicine** you are appealing about.
- And the **reason you want to appeal.** Tell TennCare as much about the problem as you can. Be sure you say what mistake you think TennCare made. Send **copies** of any papers that you think may help TennCare understand your problem.

Are you appealing because you **want to change health plans?** Tell TennCare:

- The name of **the health plan you want.**
- And, the **reason you want to change health plans.**

Are you appealing for **care you've already gotten** that you think TennCare should pay for? Tell TennCare:

- The **date** you got the care or medicine you want TennCare to pay for.
- The name of the **doctor** or **other place** that gave you the care or medicine. (If you have it, include the **address** and **phone number** of the **doctor** or **other place** that gave you the care.)

  If you paid for the care or medicine, also give TennCare a **copy of a receipt** that proves you paid. Your receipt must show:
  - The **kind of care** you got that you want TennCare to pay for
  - And the name of the **person** who got the care
  - And the name of the **doctor or other place** that gave you the care
  - And the **date** you got the care
  - And the **amount** you paid for the care

  If you're getting a bill for the care or medicine, give TennCare a **copy of a bill.** Your bill must show:
  - The **kind of care** that you're being billed for
  - And the name of the **person** who got the care
  - And the name of the **doctor or other place** that gave you the care
  - And the **date** you got the care
  - And the **amount** you are being billed

What does TennCare do when you appeal about a health care problem?

1. **When TennCare gets your appeal, they will send you a letter that says they got your appeal.** If you asked to keep getting your care during your appeal, it will say if you can keep getting your care. If you asked for an emergency appeal, it will say if you can have an emergency appeal.

2. **If TennCare needs more facts to work your appeal, you'll get a letter that says what facts they still need.** You should give TennCare all of the facts that they ask for, as soon as possible. If you don't, your appeal may end.

3. **TennCare must decide a regular appeal in 90 days.** If you have an emergency appeal, they'll try to decide your appeal in about one week (unless they need more time to get your medical records.

4. **To decide your appeal, you may need a fair hearing.** To get a fair hearing, you must say TennCare made a mistake that, if you're right, means you'll get the health care or service you're asking for. You may **not** get a fair hearing if you're asking for care or services that are not covered by TennCare. A fair hearing lets you tell a judge the mistake you think TennCare made. If TennCare says that you can have a fair hearing, you will get a letter that says when your hearing will be.

What happens at a fair hearing about health care problems?

1. **Your hearing** can be by phone or in person. The different people who may be at your hearing include:
    - a judge who does not work for TennCare,
    - a TennCare lawyer,
    - a state witness (someone like a doctor or nurse from TennCare), and you.

    You can talk for yourself. Or, you can bring someone else, like a friend or a lawyer, to talk for you.

2. **During the hearing,** you get to tell the judge about the mistake you think TennCare made. You can give the judge facts and proof about your health and medical care. The judge will listen to everyone's side.

3. **After the hearing,** you will get a letter that tells you the judge's answer. What if the judge says you win your appeal? TennCare must agree that it's the right decision based on the facts of your case. Federal law says that **a judge's decision is not final until TennCare OKs it.** If TennCare overturns a judge's decision, we must tell you why in writing.

Remember, you can find out more about your Rights to a Fair Hearing, in Part 7 of this handbook.

Administrative Appeals - Getting or keeping TennCare and other TennCare problems

An appeal about TennCare problems *other than health care* is called an **administrative appeal.** An administrative appeal goes to the Eligibility Appeals Unit at the Tennessee Health Connection.

An administrative appeal is used for TennCare problems like:

- You get a letter that says your TennCare will end,
- Or, your TennCare has ended but you didn't get a letter because you moved,
- Or, you think your TennCare co-pays are wrong,
- Or, you think TennCare gave you the wrong benefit package.

If you have a problem like one of those listed above, call the **Tennessee Health Connection** at **1-855-259-0701**. They will check to see if a mistake has been made. If they decide you're right, they will fix the problem. But if they say no, and you still think a mistake has been made in your case, **you can appeal.**

How to file an Administrative Appeal

There are 2 ways to file an administrative appeal:

1. Appeal **by phone** by calling the Tennessee Health Connection free at **1-855-259-0701**.

2. Or, appeal **in writing**. You can write your appeal on plain paper.

To file an administrative appeal in writing you must include:

- Your **full name** (first name, middle initial, last name)
- Your **Social Security number**
- The **names of other people who live with you** with the same problem
- Your **daytime phone number** and the best time to call
- The **specific mistake** you think was made. Tell as much about the problem as you can.
- Send **copies** of any papers that show why you think the mistake was made.

Then, mail your letter about your problem to:

Tennessee Health Connection
Eligibility Appeals Unit
P.O. Box 23650
Nashville, TN 37202-3650

Keep a copy of your appeal. Write down the date that you mailed it to TennCare.

Part 7: Your rights and responsibilities

Your rights and responsibilities as a TennCare and Amerigroup member

You have the right to:

- Be treated with respect and in a dignified way. You have a **right to privacy** and to have your medical and financial information treated with privacy.
- Ask for and get information about Amerigroup, its policies, its services, its caregivers, and members' rights and duties.
- Ask for and get information about how Amerigroup pays its providers, including any kind of bonus for care based on cost or quality.
- Ask for and get information about your medical records as the federal and state laws say. You can see your medical records, get copies of your medical records, and ask to correct your medical records if they are wrong.
- **Get services without being treated in a different way** because of race, color, birthplace, language, sex, age, religion, or disability. You have a right to file a complaint if you think you have been treated unfairly. If you complain or appeal, you have the right to keep getting care without fear of bad treatment from Amerigroup, providers, or TennCare.
- Get care without fear of physical restraint or seclusion used for bullying, discipline, convenience or revenge.
- Make appeals or complaints about Amerigroup or your care. Part 5 of this handbook tells you how.
- Make suggestions about your rights and responsibilities or how Amerigroup works.
- Choose a PCP in the Amerigroup network. You can turn down care from certain providers.
- Get medically necessary care that is right for you, when you need it. This includes getting **emergency services, 24 hours a day, 7 days a week.**
- Be told in an easy-to-understand way about your care and all of the different kinds of treatment that could work for you, no matter what they cost or even if they aren't covered.
- Help to make decisions about your health care.
- Make a living will or advance care plan and be told about Advance Medical Directives.
- Change health plans. If you are new to TennCare, you can change health plans once during the 45 days after you get TennCare. After that, you can ask to change health plans through an appeal process. There are certain reasons why you can change health plans. Part 5 and Part 6 of this handbook tells you more about changing health plans.
- Ask TennCare and Amerigroup to look again at any mistake you think they made about getting on TennCare or keeping your TennCare or about getting your health care.
- End your TennCare at any time.
- Exercise any of these rights without changing the way Amerigroup or its providers treat you.

Your rights to stay with Amerigroup

As an Amerigroup member, you **cannot** be moved from Amerigroup just because:

- Your health gets worse.
- You already have a medical problem. This is called a pre-existing condition.
- Your medical treatment is expensive.
- Of how you use your services.
- You have a behavioral health (mental health, alcohol or drug abuse) condition.
- Your special needs make you act in an uncooperative or disruptive way.

The only reasons you can be moved from Amerigroup are:

- If you **change** health plans.
- If you **move** out of the Amerigroup area.
- If you let someone else use your ID cards, or if you use your TennCare to get medicines to sell.
- If you end your TennCare or your TennCare ends for other reasons.
- If you don't **renew** your TennCare when it is time, or if you don't give TennCare information they ask for when it is time to renew.
- If you don't let TennCare and Amerigroup know that you moved, and they can't find you.
- If you lie to get or keep your TennCare.
- Upon your death.

You have the responsibility to:

- Understand the information in your member handbook and other papers that we send you.
- Show your Amerigroup ID card whenever you get health care. If you have other insurance, you must show that card too.
- Go to your PCP for all your medical care unless:
  - Your PCP sends you to a specialist for care. You must get a referral from your PCP to go to a specialist.
  - You are pregnant or getting well-woman checkups.
  - It is an emergency.
- Use providers who are in the Amerigroup provider network. But, you can see anyone if it is an emergency. And, you can see anyone who has been approved with a referral.
- Let your PCP know when you have had to go to the Emergency Room. You (or someone for you) need to let your PCP know by 24 hours of when you got care at the ER.
- Give information to Amerigroup and to your health care providers so that they can care for you.
- Follow instructions and rules that are in the handbook about your coverage and benefits. You must also follow instructions and rules from the people who are giving you health care.
- Help to make the decisions about your health care.

- Work with your PCP so that you understand your health problems. You must also work with your PCP to come up with a treatment plan that you both say will help you.
- Treat your health care giver with respect and dignity.
- Keep health care appointments and call the office to cancel if you can't keep your appointment.
- Not let anyone else use your Amerigroup ID card and let us know if it is lost or stolen.
- Tell the Tennessee Health Connection of any changes like:
    - If you or a family member change your name, address, or phone number.
    - If you have a change in family size.
    - If you or a family member get a job, lose your job, or change jobs.
    - If you or a family member has other health insurance or can get other health insurance.
- Pay any co-pays you need to pay.
- Let us know if you have another insurance company that should pay your medical care. The other insurance company could be insurance like auto, home, or worker's compensation.

Other rights and responsibilities as a TennCare and Amerigroup member

Your Right to Appeal Health Care Problems in TennCare

In TennCare, you get your health care through a TennCare health plan. You have rights when an action is taken that keeps you from getting health care when you need it.

1. You have the right to get an answer from your health plan when you or your doctor asks for care.

For some kinds of care, your doctor must get your health plan's OK before TennCare will pay for it. It's called a "prior authorization" or "PA." What if your doctor asks your health plan to OK care for you? Your health plan must decide in 14 days. If you can't wait 14 days for the care you need, you can ask them to decide sooner.

2. You have the right to get a letter from your TennCare plan if:

- Your TennCare health plan says **no** when you or your doctors ask for health care.
- Or, you have to wait too long to get health care.
- Or, your TennCare health plan stops or changes your health care.

The letter must say **why** you can't get the care and **what you can do** about it.

If your **health plan** decides to change care you're getting, you should get a letter at least **10 days before** it happens. If they decide to change your **hospital** care, you should get a letter **2 business days before** it happens. What if your **doctor** decides to change care you're getting? For these kinds of care, you should get a letter **2 business days before** it happens:

- Behavioral health (mental health, alcohol or drug abuse) treatment for a priority member which includes a child with Serious Emotional Disturbance (SED) or an adult with Severe and Persistent Mental Illness (SPMI)

- Behavioral health (mental health, alcohol or drug abuse) treatment in a hospital or other place where you must stay to get the care (inpatient psychiatric or residential services)
- Care for a long-term health problem when your health plan can't give you the next kind of care you need for that problem
- Home health services

3. You have the right to appeal if:

- TennCare says **no** when you or your doctors ask for health care.
- Or, TennCare stops or changes your health care.
- Or, you have to wait too long to get health care.
- Or, you have health care bills you think TennCare should have paid for, but didn't.

You **only** have **60 days** to appeal after you find out that there is a problem.
Someone who has the legal right to act for you can also file an appeal for you.

4. **You have the right to a fair hearing about your appeal if you think TennCare made a mistake.** To get a fair hearing, you must say TennCare made a mistake that, if you're right, means you'll get the health care or service you're asking for. You may **not** get a fair hearing if you're asking for care or services that are not covered by TennCare. A fair hearing lets you tell a judge the mistake you think TennCare made.

What if a judge says you win your appeal? TennCare must agree that it's the right decision based on the facts of your case. If TennCare does not agree, we can overturn the judge's decision. Federal law gives TennCare this right. If TennCare overturns a judge's decision, we must tell you why in writing. If TennCare doesn't overturn the judge's decision, TennCare has 72 hours to do what the judge ordered.

5. **If you have an emergency, you have the right to get a decision about your appeal in about one week (but it could take longer if your health plan needs more time to get your medical records).**

An emergency means that waiting 90 days for a "yes" or "no" decision could put your life or physical or mental health in real danger.

If you think you have an emergency, you can ask TennCare for an emergency appeal by calling 1-800-878-3192. Your doctor can also ask for this kind of appeal for you. But the law requires your doctor to have **your permission (OK) in writing.** Write your **name, your date of birth, your doctor's name, and your permission for them to appeal for you** on a piece of paper. Then fax or mail it to TennCare (see Part 6 of this handbook for the address and fax number).

What if you don't send us your OK and your doctor asks for an expedited appeal? TennCare will send you a page to fill out, sign and send back to us.

After you give your OK in writing, your doctor can help by completing a Provider's Expedited Appeal Certificate like the one in Part 8 of this handbook. If your appeal is an emergency, you can have your doctor sign the Provider's Expedited Appeal Certificate. Your doctor should fax the certificate to 1-866-211-7228. TennCare and your health plan will then look at your appeal and decide if it should be expedited. **If it should be**, you will get a decision on your appeal in about one week.

Remember, it could take a few more days if your health plan needs more time to get your medical records. But, if your health plan decides your appeal should not be expedited, then you will get a hearing within 90 days from the date you filed your appeal.

6. **You have the right to get a decision about your appeal within 90 days if it's not an emergency.**

7. **If you are already getting care, you may have the right to keep getting it during the appeal.** To keep getting care during your appeal, **all** of these things must be true:

   - You must appeal by the date your care will stop or change or within 10 days of the date on the letter from your health plan (whichever date is later).
   - You must say in your appeal that you want to keep getting the care during the appeal.
   - You can only ask to **keep care you've been getting** during your appeal.
   - If you needed a doctor's order to get the care, you'll still need a doctor's order to keep getting it during your appeal.
   - The care must be something that TennCare still covers.

What if you keep getting care during your appeal and you lose your appeal? You may have to pay TennCare back for that care that you got during your appeal.

Your Right to a Fair Hearing in TennCare

You have the right to:

1. Have a fair hearing with a judge if you think TennCare made a mistake. Remember, you may **not** get a fair hearing if you're asking for care or services that are not covered by TennCare.
2. Know about the hearing ahead of time.
3. Be at the hearing in person or by phone.
4. Speak for yourself at the hearing.
5. Have someone help you at the hearing.
6. See the facts TennCare and your health plan used to decide about your care. You can see this information **before** the hearing.
7. Look at your medical records and use them as proof.
8. Give the judge other proof that shows why TennCare made the wrong decision.
9. Bring witnesses with you.
10. Have the judge order your witnesses to come.
11. Question witnesses for TennCare.
12. Ask to have a doctor who does not work for TennCare say what medical care you need. You do **not** have to pay for this.
13. Get a written decision in 90 days (sooner if it's an emergency appeal).
14. If TennCare overturns a judge's decision, have TennCare tell you why in writing.

TennCare Notice of Privacy Practices

This notice describes how Personal Information about you may be used and disclosed. It also tells you how you can get access to this information. **Please review it carefully.**

Your TennCare is **not** changing. You don't have to do anything.

These papers tell you how we keep your Personal Information private. The federal government tells us we must give you these papers. These papers tell you:

1. the kinds of Personal Information we have,
2. how we share it,
3. who we share it with,
4. what to do if you don't want your Personal Information shared with certain people,
5. and your rights about your Personal Information.

1. The kinds of Personal Information we have:

When you applied for TennCare you told us certain facts about you. Like your name, where you live, and how much money you make. We may also have health facts like:

- A list of the health services and treatments you get.
- Notes or records from you doctor, drug store, hospital, or other health care providers.
- Lists of the medicine you take now or have taken before.
- Results from X-rays and lab tests.
- Genetic information ("genetics" are family traits like hair color or eye color. It can also be health conditions that you have in common with your blood relatives.)

Your Health Information is Private.

As the Tennessee Medicaid agency, Federal Law allows us to keep and use this type of information. Federal law says we must follow privacy rules and keep your Personal Information private. Everyone who works with us and for us must also follow these privacy rules.

2. How we use or share your Personal Information:

We can only use or share your Personal Information as the law lets us. The privacy rules let us use or share Personal Information <u>without asking for your permission</u> to:

- Show you have TennCare and to help you get the health care you need.
- Pay your health plan and health care providers.
- Check how TennCare benefits are being used and to check for insurance fraud.

3. Who can we share your Personal Information with and not get your permission?

- With you. We can help you schedule checkups and send you news about health services.
- Other people involved in your care, like family members or caregivers. You can also ask us not to share your Personal Information with certain people.

And we can share your Personal Information with people who work with TennCare like:

- Health providers like doctors, nurses, hospitals, and clinics.
- Your health plan or other companies that have contracts with TennCare.
- People helping with appeals if you file a TennCare appeal. Your appeal may be in person or over the phone. Sometimes other people may be with you in your appeal hearing.
- Federal, state, or local government agencies providing or checking on health care.

Who else can we share your Personal Information with? The privacy rules also say we can share Personal Information with people like:

- Coroners, funeral homes, or providers who work with services like organ transplants.
- Medical researchers. They must keep your Personal Information private.
- Public health agencies to update their records for births, deaths, or to track diseases.
- The court when the law says we must or when we are ordered to.
- The police or for other legal reasons. We can report abuse or neglect.
- Other agencies – like for military or veterans' activities, national security, jails.

We can also share your Personal Information if we take out the information that tells who you are. **But, we can't share your Personal Information with just anyone. And even when we do share it, we can only share the information the person needs to actually do their job.** And we can't share your genetic information to make decisions about your eligibility for TennCare.

Sometimes we'll need your OK in writing before we can share your Personal Information. We'll ask you to sign a paper giving us your OK if we need to use or share (disclose) any of the following information:

1. To use or share notes a therapist takes during therapy sessions (these are called psychotherapy notes);
2. To use or share Personal Information with companies who will use the information to try to get other people's business (for marketing purposes); **and**
3. Sharing (disclosures) Personal Information with someone else for money.

Can you take back your OK? Yes. You can take back your OK anytime. But you must tell us in writing. We can't take back the Personal Information we have already shared.

4. What if you don't want all of your Personal Information shared?

You must ask us in writing if you don't want us to share your Personal Information. You must tell us the Personal Information you don't want shared and who you don't want us to share your Personal Information it with. For example, you can ask us not to share your Personal Information if:

- You paid for your care out of your own pocket **and**
- You asked your doctor not to share your Personal Information for that care.

There are other times when we won't share your Personal Information if you ask us. We'll say OK if we can. But we might not say OK if you are a minor child **or** if we're allowed to share the Personal Information by law. If we can't say OK, we will send you a letter that says why. What if you don't ask us to not share your Personal Information? We may use and share it only as explained in this notice.

5. Your health information rights:

- You can see and get copies of your records in paper. Or, if we have them in electronic form, you can get them electronically. You must ask in writing to do so. You may have to pay money for the cost of copying and mailing your copies. If we can't give you the Personal Information you want, we'll send you a letter that says why.
- You can ask us in writing not to share certain facts about your health.
- You can ask us to not show your Personal Information in certain records.
- You can ask us not to send you letters about fundraising.
- You can ask us to change Personal Information that's wrong. You must ask in writing and tell us why we need to change it. If we can't make the change, we'll send a letter that says why.
- You can ask us in writing to contact you in a different way or in a different place. If writing or talking to you puts you in danger, tell us.

- You can ask us in writing for a list of who we've shared your Personal Information with. The list will say who got your health facts for the six (6) years before the date of your request. But it won't list the times we've shared when you've given us your OK or other times when the law says we didn't need to get your permission. Like when we use Personal Information:
  - to help you get health care, or
  - to help with payment for your care, or
  - to run our program, or
  - to give to law enforcement if we're required by law to do so

TennCare's Responsibility to You

TennCare keeps your Personal Information safe. We protect its privacy and security. If your Personal Information gets out, we have must tell you and federal authorities. But we only have to tell you:

- If the kind of Personal Information that got out would identify who you are (like your Social Security number or your date of birth) or your treatment records, **and**
- If anyone actually used or saw your Personal Information, **and**
- Depending on who the person was that used or saw your Personal Information, **and**
- What we did to lower the risk that your Personal Information was used by whoever got it.

Requests – Ask us in Writing

Your requests must be in writing. Be sure you tell us what you're asking us to do. Write your name, date of birth and TennCare ID number **or** last four digits of your Social Security number on your letter. Send your letter to:

TennCare Privacy Officer
Division of TennCare
310 Great Circle Road
Nashville, TN 37228

Keep a copy of the letter for your records. Do you have questions? Do you need help making your request? Call the Tennessee Health Connection at **1-855-259-0701** for free.

Changes to this Notice

TennCare's policies and procedures about requests may change without notice. We'll use the policies and procedures we have in place when you make your request.

Federal privacy rules and TennCare privacy practices may also change. If important changes are made, we'll send you the changes in writing. We have the right to make the changes to all the health facts we have. Or only to new health facts we get.

This notice was updated as of May 13, 2016 and applies to all health facts we have. If you need a new copy or want to check for changes, go to http://www.tn.gov/tenncare/topic/hipaa-privacy-information. The notice is found under "Notice of Privacy Practices."

Questions or Complaints

We do not allow unfair treatment in TennCare. No one is treated in a different way because of race, color, birthplace, language, sex, age, or disability. You will not be punished if you complain or ask for help. Do you have questions? Do you think your privacy rights have been violated? Do you think you have been treated unfairly? Call the Tennessee Health Connection at **1-855-259-0701** for free. Or you can write to:

Division of TennCare Attn: Privacy Office 310 Great Circle Road Nashville, TN 37243 Phone: 1-615-507-6820 Fax: 1-615-734-5289		U.S. Dept. of Health and Human Services Region IV, Office of Civil Rights Medical Privacy Complaint Division Atlanta Federal Center Suite 3B70 61 Forsyth Street, SW Atlanta, GA 30303-8931 Phone: 1-866-627-7748 TDD: 1- 404-562-7884
Email: Privacy.TennCare@tn.gov		Website: www.hhs.gov/ocr

Your responsibility to report fraud and abuse

Most TennCare members and providers are honest. But even a few dishonest people can hurt the TennCare program. People who lie on purpose to get TennCare may be fined or sent to jail.

If you find out about a case of fraud and abuse in the TennCare program, you must tell us about it. But you don't have to tell us your name.

Fraud and abuse for **TennCare members** can be things like:

- Lying about facts to get or keep TennCare.
- Hiding any facts so that you can get or keep TennCare.
- Letting someone else use your TennCare ID card.
- Selling or giving your prescription medicines to anyone else.

Fraud and abuse for TennCare providers can be things like:

- Billing TennCare for services that were never given.
- Billing TennCare twice for the same service.

To tell us about fraud and abuse, call **Amerigroup for free at 1-800-600-4441**.

Here are some other places that you can call or write to tell us about fraud and abuse:

Agency	Phone	Address
Office of Inspector General (OIG)	1-800-433-3982 toll-free	Office of Inspector General P.O. Box 282368 Nashville, TN 37228
Tennessee Bureau of Investigation (TBI)	1-800-433-5454 toll-free	TBI Medicaid Fraud Control Unit 901 R.S. Gass Blvd. Nashville, TN 37216

You can also tell us about fraud and abuse online at: **https://www.tn.gov/tenncare/fraud-and-abuse.html**

Part 8: Health Care Papers You May Need

Primary Care Provider (PCP) Change Request

Fill this out and mail to: **Amerigroup Community Care**
22 Century Blvd., Suite 220
Nashville, TN 37217

When you choose a PCP, we will send you a new ID card.
You can begin seeing your new PCP on the effective date on your new card.

Member Information:

Your Name: ____
Last First MI

Your Street Address: _______________________________________

City: ____________________ State:_____ ZIP Code:_________

Your ID number: _________________________Your Birth Date: ______/_____/_____
Month Day Year

Your Telephone Number: (_____)______________________
Area code Number

PCP 1st Choice:

Name of PCP you want: ____
Last First

Address: ____

Telephone Number: (_____)_______________________
Area code Number

Provider ID number (listed in the Provider Directory): ____________________

PCP 2nd Choice:

Name of PCP you want: ____
Last First

Address: ____

Telephone Number: (_____)_______________________
Area code Number

Provider ID number (listed in the Provider Directory): ____________________

Division of TennCare

Discrimination Complaint Form

Federal and State laws do not allow TennCare to treat you differently because of your **race, color, birthplace, disability, age, sex, religion, or any other group protected by law**. Do you think you have been treated differently for these reasons? Use these pages to report a complaint to TennCare.

The information marked with a star (*) must be answered. If you need more room to tell us what happened, use other sheets of paper and mail them with your complaint.

1.* Write your name and address.

Name: ____

Address: ____

______________________________________ ZIP: ______________

Telephone Home: (____) ____________ Work or Cell: (____) __________________

Email Address: _______________________________________

Name of MCO/Health Plan: _______________________________

2.* Are you reporting this complaint for someone else? Yes: _______ No: ________

If Yes, who do you think was treated differently because of their **race, color, birthplace, disability, age, sex, religion, or any other group protected by law?**

Name: ____

Address: ____

______________________________________ ZIP: ______________

Telephone Home: (____) ____________ Work or Cell: (____) __________________

How are you connected to this person (spouse, brother, friend)? __________________

____

Name of this person's MCO/Health Plan: __________________________

3.* Which part of the TennCare Program do you think treated you in a different way:

Medical Services_____ Dental Services_____ Pharmacy Services_____ Other______
Long-Term Services & Supports_____ Eligibility Services_____ Appeals_____

4.* How do you think you were treated in a different way? Was it your

Race _____ Birthplace _____ Color _____ Sex _____ Age _____
Disability ____ Religion ____ Other _____

5. What is the best time to talk to you about this complaint?

____

6.* When did this happen to you? Do you know the date?

Date it started ______________

Date of the last time it happened ____

7. Complaints must be reported by 6 months from the date you think you were treated in a different way. You may have more than 6 months to report your complaint if there is a good reason (like a death in your family or an illness) why you waited. ________________________

____

____

8.* What happened? How and why do you think it happened? Who did it? Do you think anyone else was treated in a different way? You can write on more paper and send it in with these pages if you need more room.____

____

____

9. Did anyone see you being treated differently or is there anyone who would have more information about what happened? If so, please tell us his/her:

Name: ____

Address: ____

____

Telephone: (____) ____

10. Do you have more information you want to tell us about? ________________________

____

____

11.* We cannot take a complaint that is not signed. Please write your name and the date on the line below. Are you the Authorized Representative of the person who thinks they were treated differently? Please sign your name below. As the Authorized Representative, you must have proof that you can act for this person. If the person is less than 18 years old, a parent or guardian should sign for the minor. **Declaration:** *I agree that the information in this complaint is true and correct and give my OK for TennCare to investigate my complaint.*

____

(Sign your name here if you are the person this complaint is for) (Date)

____

(Sign here if you are the Authorized Representative) (Date)

Are you reporting this complaint for someone else but you are **not** the person's Authorized Representative? Please sign your name below. **The person you are reporting this complaint for must sign above or must tell us or TennCare that it is okay for them to sign for him/her.**

Declaration: *I agree that the information in this complaint is true and correct and give my OK for HCFA to contact me about this complaint.*

____

(Sign here if you reporting this for someone else) (Date)

Are you a helper from TennCare or somewhere else assisting the person in good faith with the completion of the complaint? If so, please sign below:

____

(Sign here if you are a helper) (Date)

It is okay to report a complaint to us or TennCare. Information in this complaint is treated privately. Names or other information about people used in this complaint are shared only when needed. Please mail a signed Agreement to Release Information page with your complaint. If you are filing this complaint on behalf of someone else, have that person sign the Agreement to Release Information page and mail it with this complaint. Keep a copy of everything you send. Please mail the completed, signed Complaint **and** the signed Agreement to Release Information pages to:

Office of Civil Rights Compliance (OCRC)
310 Great Circle Road; Floor 3W
Nashville, TN 37243
615-507-6474 or for free at **1-855-857-1673 (TRS 711)**
HCFA.fairtreatment@tn.gov

TN Division of TennCare

Agreement to Release Information

To investigate your complaint, TennCare or a TennCare Contractor may need to tell other persons or agencies important to this complaint your name or other information about you. TennCare is made up of these programs:

● TennCare ● CoverKids ● AccessTN ● CoverRX
● Office of eHealth Initiatives ● Strategic Planning and Innovation Group

To speed up the investigation of your complaint, read, sign, and mail one copy of this Agreement to Release Information with your complaint. Please keep one copy for yourself.

- I understand that during the investigation of my complaint TennCare ____ (write name of TennCare Contractor on the line) may need to tell people my name or other information about me to other persons or agencies. For example, if I report that my doctor treated me in a different way because of my color, my MCO/Health Plan may need to talk to my doctor.

- You do not have to agree to release your name or other information. It is not always needed to investigate your complaint. If you do not sign the release, we will still try to investigate your complaint. But, if you don't agree to let us use your name or other details, it may limit or stop the investigation of your complaint. And, we may have to close your case. However, before we close your case if your complaint can no longer be investigated because you did not sign the release, we may contact you to find out if you want to sign a release so the investigation can continue.

If you are filing this complaint for someone else, we need that person to sign the Agreement to Release Information. Are you signing this as an Authorized Representative? Then you must also give us a copy of the documents appointing you as the Authorized Representative.

By signing this Agreement to Release Information, I agree that I have read and understand my rights written above. I agree to TennCare telling people my name or other information about me to other persons or agencies important to this complaint during the investigation and outcome.

By signing this Agreement to Release Information, I agree that I have read and understand my rights written above. I agree to my MCO/Health Plan or TennCare Contractor telling people my name or other information about me to other persons or agencies important to this complaint during the investigation and outcome.

This Agreement to Release Information is in place until the final outcome of your complaint. You may cancel your agreement at any time by calling or writing to TennCare without canceling your complaint. If you end the Release Agreement, it only applies to the future sharing of information. This will not change information that has already been shared about you. But we will not share any more information.

Signature: ______________________________________ Date: ______________________

Name (Please print): ____

Address: ____

Telephone: (____) ____

Need help? Please contact or mail a completed**, <u>signed Complaint and a signed Agreement to Release Information form:</u>**

TennCare, Office of Civil Rights Compliance (OCRC)
310 Great Circle Road; Floor 3W
Nashville, TN 37243
615-507-6474 or for free at **855-857-1673 (TRS 711)**
HCFA.fairtreatment@tn.gov

If you change your mind and want to end the Release Agreement, contact OCRC.

Having problems getting health care or medicine in TennCare?

Use this page **only** to file a

TennCare Medical Appeal.

Need help filing a medical appeal?
☐ Call **1-800-878-3192** for free.

Fill out **both** pages. These are **facts we must have to work your appeal.** If you don't tell us all the facts we need, we may not be able to decide your appeal. You may **not** get a fair hearing. Need help understanding what facts we need? Call us for free at **1-800-878-3192.** If you call, we can also take your **appeal by phone.**

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1. Who is the person that wants to appeal?

Full name____ Date of birth____/____/_____

Social Security Number_____-____-_____ Or number on their TennCare card____________________

Current mailing address____

City_____________________________________ State ___________ Zip Code____________

The name of the person we should call if we have questions about this appeal:____________________

A daytime phone number for that person (_____)______-____________

2. Who filled out this form?

If **not** the person that wants to appeal, tell us your name.______________________________________

Are you a: ____ Parent, relative, or friend ____ Advocate or attorney ____ Doctor or health care provider*
(*You need your patient's written permission to file this appeal. See the third page.)

3. What is the appeal for? (Place an X beside the right answer below.)

___ Want to **change health plans.** (Fill out **Part A** on page 2.)

___ **Need care or medicine.** (Fill out **Part B** on page 2.)

___ Have **bills or paid for care or medicine** you think TennCare should pay. (Fill out **Part C** on page 2.)

4. Do you think you have an emergency?

Usually, your appeal is decided within **90 days** after you file it. But, if you have an emergency and your health plan agrees that you do, you will get an **expedited** appeal. An expedited appeal will be decided in about one week. It could take longer if your health plan needs more time to get your medical records. An emergency means that waiting 90 days for a "yes" or "no" decision **could put your life or physical or mental health in real danger:**

Do you still think you have an emergency? If so, you can ask TennCare for an **expedited** appeal by calling 1-800-878-3192. Your **doctor** can also ask for this kind of appeal for you. But the law requires your doctor to have **your permission (OK) in writing.** Write **your name, your date of birth, your doctor's name, and your permission for them to appeal for you** on a piece of paper. Then fax or mail it to TennCare (see **There are 3 ways to file an appeal** for our address and fax number). What if you don't send us your OK and your doctor asks for an expedited appeal? TennCare will send you a page to fill out. Sign and send back to us.

After you give your OK in writing, your doctor can help by completing a "Provider's Expedited Appeal Certificate." Your doctor can get the page from TennCare's website. **Go to tn.gov/tenncare.** Click "Providers," and then click "Miscellaneous Provider Forms." Your doctor should fax this certificate and your medical records to TennCare. TennCare **and** your health plan will then look at your appeal and decide if it should be expedited. **If it should be**, you will get a decision on your appeal in about one week. Remember it could take a few more days if your health plan needs more time to get your medical records.

TC-0182 (Rev. 01Jan18) RDA 2578

5. Tell us why you want to appeal this problem. Include any mistake you think TennCare made. And, send copies of any papers that you think may help us understand your problem.

____

____

____

To see which Part(s) you should fill out below, look at number **3** on page 1.

Part A. Want to change health plans. Name of health plan you want ________________

Part B. Need care or medicine. What kind - be specific ____________________________

What's the problem? ___ Can't get the care or medicine at all.

___ Can't get as much of the care or medicine as I need.

___ The care or medicine is being cut or stopped.

___ Waiting too long to get the care or medicine.

Did your doctor prescribe the care or medicine? __Yes __No If yes, doctor's name_______________

Have you asked your health plan for this care or medicine? ___Yes ___No If yes, when? _________

What did they say? ____

Did you get a letter about this problem? ___Yes ___No If yes, the date of the letter_______________

Who was the letter from? ____

Are you getting this care or medicine from TennCare now? ___ Yes ___ No

Do you want to see if you can keep getting it during your appeal? ___ Yes ___ No

Does your doctor say you still need it? ___ Yes ___ No If yes, doctor's name _________________

If you keep getting care or medicine during your appeal and you lose, you may have to pay TennCare back.

Part C. Bills for care or medicine you think TennCare should pay for

The date you got the care or medicine_____________ Name of doctor, drug store, or other place that gave you the care or medicine________________Their phone number (____)_____-________

Their address ____

Did you **pay for the care or medicine and want to be paid back?** ___ Yes ___ No

If yes, you must send a copy of a **receipt** that proves you paid for the care or medicine.

If you didn't pay, **are you getting a bill?** ___ Yes ___ No If yes, and you think TennCare should pay, you must send a copy of a **bill.** Tell us the date you first got a bill (if you know). ___________

How to file your medical appeal **Make a copy of the completed pages** to keep.

Then, **mail** these pages and other facts to:

TennCare Solutions
P.O. Box 593
Nashville, TN 37202-0593

Or, **fax** it (toll-free) to **1-888-345-5575. Keep a copy** of the page that shows your fax went through.

To appeal by **phone**, call **1-800-878-3192** for free.
Have speech or hearing problems? Call our TTY/TDD line for free at **1-866-771-7043**.

We do not allow unfair treatment in TennCare.

No one is treated in a different way because of race, color, birthplace, language, sex, age, religion, disability. If you think you've been treated unfairly, call the Tennessee Health Connection for free at **1-855-259-0701.**

TC-0182 (Rev. 01Jan18) RDA 2578

STATE OF TENNESSEE
DIVISION OF TENNCARE
TennCare Solutions Unit
P.O. Box 000593
Nashville, Tennessee 37202-0593

Appeal Authorization Form

Patient's Printed Name________________________________

Patient's Date of Birth_________________________________

Doctor's Printed Name_________________________________

Yes, I would like to request a Fair Hearing from TennCare for

____.
(Drug, item, or service)

☐ I give my doctor permission to file a fair hearing request on my behalf.

☐ I want to keep getting the services I've been getting until my appeal is over. I understand that my health plan will look at my case and decide if I can keep getting this care during my appeal.

___________________________________ _________________

Signature of Patient **Date**

____

Address

____

Phone Number

Treating Provider's Certificate: *Expedited* TennCare Appeal

A typical appeal for a medical service is decided in up to ninety (90) days. However, an expedited appeal, because of a patient's health, must be decided within one week (or up to three weeks if the health plan is given additional time to obtain and review a patient's medical records). An appeal will only be expedited if waiting up to ninety (90) days for a decision, "could seriously jeopardize the enrollee's life, physical health, or mental health or their ability to attain, regain, or maintain full function."

To request an expedited appeal for your patient:

1. Read the statement below. If you agree, indicate your certification and sign and date in the spaces provided.

☐ I certify that I am the treating clinician of the patient named below, and that ***the acute presentation of this medical condition is of sufficient severity that waiting up to ninety (90) days for a decision on an appeal could seriously jeopardize the enrollee's life, physical health, or mental health or their ability to attain, regain, or maintain full function.***

Provider's Signature:___________________________________ Date:_________________

2. Identify the desired service:____

3. Identify the patient.

____
(Name) (SS#) **or** (date of birth)

4. At your discretion, please attach a narrative and/or medical records that support this request.

5. **Please attach** a copy of your office's **letterhead** so that TennCare has your contact information.

6. Fax this completed form and any accompanying documentation to the **Division of TennCare** at **1-866-211-7228**. (NOTICE: If your patient has already requested this expedited appeal from TennCare, please submit this certificate and documentation as soon as possible.)

Advance Directives

Advance Directives are your written wishes about what you want to happen, if you get too sick to be able to say.

Living Will or Advance Care Plan

Machines and medicine can keep people alive when they otherwise might die. Doctors used to decide how long someone should be kept alive. Under the Tennessee Right to Natural Death Act, you can make your own choice. **You can decide if you want to be kept alive by machines and for how long** by filling out a Living Will. In 2004, Tennessee law changed the Living Will to **Advance Care Plan**. Either one is ok to use.

A Living Will or Advance Care Plan needs to be filled out while you can still think for yourself. These papers tell your friends and family what you want to happen to you, if you get too sick to be able to say.

Your papers have to be signed, and either witnessed or notarized.

If your papers are witnessed, your papers need to be signed in front of two people who will be your witnesses. These people:

- One of these people cannot be related to you by blood or marriage.
- Cannot receive anything you own after you die.
- Cannot be your doctor or any of the staff who work in the place where you get health care.

Once they are signed by everyone, it is your rule. It stays like this unless you change your mind.

Tennessee Durable Power of Attorney for Health Care or Appointment of Health Care Agent

The Durable Power of Attorney for Health Care paper lets you name another person to make medical decisions for you. In 2004, Tennessee law changed the Durable Power of Attorney for Health Care to **Appointment of Health Care Agent.** Either one is ok to use.

This person can only make decisions if you are too sick to make your own. He or she can say your wishes for you if you can't speak for yourself. Your illness can be temporary.

These papers have to be signed, and either witnessed or notarized. Once the papers are signed by everyone, it is your rule. It stays like this unless you change your mind.

These papers will only be used if you get too sick to be able to say what you want to happen. As long as you can still think for yourself, you can decide about your health care **yourself**.

If you fill out these papers, make **3** copies:

- **Give** 1 copy to your PCP to put in your medical file.
- **Give** 1 copy to the person who will make a medical decision for you.
- **Keep** a copy with you to put with your important papers.

Important! You **do not** have to fill out these papers. It is your choice. You may want to talk to a lawyer or friend before you fill out these papers.

Instructions: Parts 1 and 2 may be used together or independently. Please mark out/void any unused part(s). Part 5, Block A or Block B must be completed for all uses.

ADVANCE DIRECTIVE FOR HEALTH CARE*
(Tennessee)

I, ____________________________________, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Part I **Agent:** I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: ____________________ Relation: ______________ Home Phone: ______________ Work Phone: ______________
Address: ____________________________________ Mobile Phone: ______________ Other Phone: ______________

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: ____________________ Relation: ______________ Home Phone: ______________ Work Phone: ______________
Address: ____________________________________ Mobile Phone: ______________ Other Phone: ______________

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

Part 2 **Indicate Your Wishes for Quality of Life:** By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes ☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes ☐ No	**Permanent Confusion:** I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
☐ Yes ☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes ☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.

Indicate Your Wishes for Treatment: If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

☐ Yes ☐ No	**CPR (Cardiopulmonary Resuscitation):** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
☐ Yes ☐ No	**Life Support / Other Artificial Support:** Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
☐ Yes ☐ No	**Treatment of New Conditions:** Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
☐ Yes ☐ No	**Tube feeding/IV fluids:** Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Part 3 **Other instructions, such as hospice care, burial arrangements, etc.:** ____

____

____

____

____

(Attach additional pages if necessary)

Part 4 Organ donation: Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues: ______________

____

☐ No organ/tissue donation

SIGNATURE

Part 5 Your signature must **either** be witnessed by two competent adults ("Block A") **or** by a notary public ("Block B").

Signature: ____ Date: ______________________
(Patient)

Block A Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

1. I am a competent adult who is not named as the agent. I I witnessed the patient's signature on this form.

   ____
   Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

   Signature of witness number 2

Block B You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

STATE OF TENNESSEE
COUNTY OF ______________________________

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _________________

____
Signature of Notary Public

<u>WHAT TO DO WITH THIS ADVANCE DIRECTIVE</u>: (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; (4) provide a copy to the person(s) you named as your health care agent.

* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.

Part 9: More information

TennCare Kids:
TennCare's Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Under TennCare Kids/EPSDT <u>for children under 21</u>, we cover:

- Regular, periodic visits to the doctor to see if the child is developing normally and to see if he or she has any physical or behavioral health (mental health, alcohol or drug abuse) problems, dental, or other conditions. These visits are called "screenings" (or "screens") and need to happen according to the American Academy of Pediatrics (AAP) Periodicity Schedule.

  For example:
  Children from birth through age 30 months have the right to get 12 screens
  Children from age 3 through age 11 have the right to get 9 screens
  Children from age 12 through age 20 have the right to get 9 screens

  *In addition, a child has a right to get a "screening" whenever the child is referred to a doctor by someone such as a teacher who notices a change in the child's health or behavior.

- TennCare Kids/EPSDT screenings include the following:

  - A comprehensive health and development history
  - A comprehensive, unclothed physical exam
  - Appropriate immunizations (shots)
  - Appropriate vision and hearing tests
  - Appropriate laboratory tests
  - Developmental/behavioral screening (as needed)
  - Health education (advice on how to keep your child healthy)

You also get other services in addition to screening services:

- Treatment, including rehabilitation, for any health problems (physical, mental or developmental) or other conditions discovered during a "screening." You can also get scheduling assistance for services.
- Regular visits to a dentist for checkups and treatment;
- Regular, periodic tests of the child's hearing and eyesight. Includes treatment of any problems with hearing and eyesight;
- Immunizations (shots) for diphtheria, tetanus, pertussis, polio, measles, mumps, rubella (MMR), HIB, influenza, hepatitis A and B vaccines, varicella, rotavirus, human papillomavirus (HPV) and meningitis, pneumococcal; and

- Routine lab tests. (**Note** a test for lead in the blood and sickle cell anemia will be done if the child is in a situation that might put him or her at risk for either or both of these things)
- If your child has a high level of lead in his or her blood, lead investigations will be done. If you think that your child has been around things that have a high lead content, such as old paint, tell your doctor; and
- Health education; and
- Transportation and scheduling assistance: If you can't get your child to his or her health visits, you may be able to get a ride. Transportation and scheduling help is available when you have to go far away from home to get to and from care. Transportation help for a child includes costs for travel, cost of meals, and a place to stay. It may also include someone to go with the child if necessary. Call your health plan to schedule your **TennCare Kids** appointment and transportation; and
- Other necessary health care, diagnostic services, treatment and other measures necessary to correct improve defects or prevent defects from worsening; if your child has physical and mental illnesses and conditions that are found in the screening process, they are treated.
- Basic health education for child and parents is part of the preventive services TennCare gives you.

Co-payments are not required for preventive services.

TennCare Kids: Children and Teen Immunization Schedule

Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger, UNITED STATES, 2018

- Consult relevant ACIP statements for detailed recommendations (www.cdc.gov/vaccines/hcp/acip-recs/index.html).
- When a vaccine is not administered at the recommended age, administer at a subsequent visit.
- Use combination vaccines instead of separate injections when appropriate.
- Report clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS) online (www.vaers.hhs.gov) or by telephone (800-822-7967).
- Report suspected cases of reportable vaccine-preventable diseases to your state or local health department.
- For information about precautions and contraindications, see www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.

Approved by the

Advisory Committee on Immunization Practices
(www.cdc.gov/vaccines/acip)

American Academy of Pediatrics
(www.aap.org)

American Academy of Family Physicians
(www.aafp.org)

American College of Obstetricians and Gynecologists
(www.acog.org)

This schedule includes recommendations in effect as of January 1, 2018.

The table below shows vaccine acronyms, and brand names for vaccines routinely recommended for children and adolescents. The use of trade names in this immunization schedule is for identification purposes only and does not imply endorsement by the ACIP or CDC.

Vaccine type	Abbreviation	Brand(s)
Diphtheria, tetanus, and acellular pertussis vaccine	DTaP	Daptacel Infanrix
Diphtheria, tetanus vaccine	DT	No Trade Name
Haemophilus influenzae type B vaccine	Hib (PRP-T) Hib (PRP-OMP)	ActHIB Hiberix PedvaxHIB
Hepatitis A vaccine	HepA	Havrix Vaqta
Hepatitis B vaccine	HepB	Engerix-B Recombivax HB
Human papillomavirus vaccine	HPV	Gardasil 9
Influenza vaccine (inactivated)	IIV	Multiple
Measles, mumps, and rubella vaccine	MMR	M-M-R II
Meningococcal serogroups A, C, W, Y vaccine	MenACWY-D MenACWY-CRM	Menactra Menveo
Meningococcal serogroup B vaccine	MenB-4C MenB-FHbp	Bexsero Trumenba
Pneumococcal 13-valent conjugate vaccine	PCV13	Prevnar 13
Pneumococcal 23-valent polysaccharide vaccine	PPSV23	Pneumovax
Poliovirus vaccine (inactivated)	IPV	IPOL
Rotavirus vaccines	RV1 RV5	Rotarix RotaTeq
Tetanus, diphtheria, and acellular pertussis vaccine	Tdap	Adacel Boostrix
Tetanus and diphtheria vaccine	Td	Tenivac No Trade Name
Varicella vaccine	VAR	Varivax
Combination Vaccines		
DTaP, hepatitis B and inactivated poliovirus vaccine	DTaP-HepB-IPV	Pediarix
DTaP, inactivated poliovirus and *Haemophilus influenzae* type B vaccine	DTaP-IPV/Hib	Pentacel
DTaP and inactivated poliovirus vaccine	DTaP-IPV	Kinrix Quadracel
Measles, mumps, rubella, and varicella vaccines	MMRV	ProQuad

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Figure 1. Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger—United States, 2018.
(FOR THOSE WHO FALL BEHIND OR START LATE, SEE THE CATCH-UP SCHEDULE [FIGURE 2]).

These recommendations must be read with the footnotes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars in Figure 1. To determine minimum intervals between doses, see the catch-up schedule (Figure 2). School entry and adolescent vaccine age groups are shaded in gray.

Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	19-23 mos	2-3 yrs	4-6 yrs	7-10 yrs	11-12 yrs	13-15 yrs	16 yrs	17-18 yrs
Hepatitis B[1] (HepB)	1st dose	←--- 2nd dose ---→					←--- 3rd dose ---→										
Rotavirus[2] (RV) RV1 (2-dose series); RV5 (3-dose series)			1st dose	2nd dose	See footnote 2												
Diphtheria, tetanus, & acellular pertussis[3] (DTaP: <7 yrs)			1st dose	2nd dose	3rd dose			←--- 4th dose ---→				5th dose					
Haemophilus influenzae type b[4] (Hib)			1st dose	2nd dose	See footnote 4		←--- 3rd or 4th dose, See footnote 4 ---→										
Pneumococcal conjugate[5] (PCV13)			1st dose	2nd dose	3rd dose		←--- 4th dose ---→										
Inactivated poliovirus[6] (IPV: <18 yrs)			1st dose	2nd dose			←--- 3rd dose ---→					4th dose					
Influenza[7] (IIV)									Annual vaccination (IIV) 1 or 2 doses						Annual vaccination (IIV) 1 dose only		
Measles, mumps, rubella[8] (MMR)					See footnote 8		←--- 1st dose ---→					2nd dose					
Varicella[9] (VAR)							←--- 1st dose ---→					2nd dose					
Hepatitis A[10] (HepA)								←--- 2-dose series, See footnote 10 ---→									
Meningococcal[11] (MenACWY-D ≥9 mos; MenACWY-CRM ≥2 mos)						See footnote 11								1st dose		2nd dose	
Tetanus, diphtheria, & acellular pertussis[13] (Tdap: ≥7 yrs)														Tdap			
Human papillomavirus[14] (HPV)														See footnote 14			
Meningococcal B[12]															See footnote 12		
Pneumococcal polysaccharide[5] (PPSV23)														See footnote 5			

- Range of recommended ages for all children
- Range of recommended ages for catch-up immunization
- Range of recommended ages for certain high-risk groups
- Range of recommended ages for non-high-risk groups that may receive vaccine, subject to individual clinical decision making
- No recommendation

NOTE: The above recommendations must be read along with the footnotes of this schedule.

FIGURE 2. Catch-up immunization schedule for persons aged 4 months–18 years who start late or who are more than 1 month behind—United States, 2018.

The figure below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. Always use this table in conjunction with Figure 1 and the footnotes that follow.

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses: Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Children age 4 months through 6 years					
Hepatitis B[1]	Birth	4 weeks	8 weeks ***and*** at least 16 weeks after first dose. Minimum age for the final dose is 24 weeks.		
Rotavirus[2]	6 weeks Maximum age for first dose is 14 weeks, 6 days	4 weeks	4 weeks[2] Maximum age for final dose is 8 months, 0 days.		
Diphtheria, tetanus, and acellular pertussis[3]	6 weeks	4 weeks	4 weeks	6 months	6 months[3]
Haemophilus influenzae type b[4]	6 weeks	4 weeks if first dose was administered before the 1st birthday. 8 weeks (as final dose) if first dose was administered at age 12 through 14 months. No further doses needed if first dose was administered at age 15 months or older.	4 weeks[4] if current age is younger than 12 months **and** first dose was administered at younger than age 7 months, **and** at least 1 previous dose was PRP-T (ActHib, Pentacel, Hiberix) or unknown. 8 weeks ***and*** age 12 through 59 months (as final dose)[4] • if current age is younger than 12 months **and** first dose was administered at age 7 through 11 months; OR • if current age is 12 through 59 months **and** first dose was administered before the 1st birthday, **and** second dose administered at younger than 15 months; OR • if both doses were PRP-OMP (PedvaxHIB; Comvax) **and** were administered before the 1st birthday. No further doses needed if previous dose was administered at age 15 months or older.	8 weeks (as final dose) This dose only necessary for children age 12 through 59 months who received 3 doses before the 1st birthday.	
Pneumococcal conjugate[5]	6 weeks	4 weeks if first dose administered before the 1st birthday. 8 weeks (as final dose for healthy children) if first dose was administered at the 1st birthday or after. No further doses needed for healthy children if first dose was administered at age 24 months or older.	4 weeks if current age is younger than 12 months and previous dose given at <7 months old. 8 weeks (as final dose for healthy children) if previous dose given between 7-11 months (wait until at least 12 months old); OR if current age is 12 months or older and at least 1 dose was given before age 12 months. No further doses needed for healthy children if previous dose administered at age 24 months or older.	8 weeks (as final dose) This dose only necessary for children aged 12 through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age.	
Inactivated poliovirus[6]	6 weeks	4 weeks[6]	4 weeks[6] if current age is <4 years 6 months (as final dose) if current age is 4 years or older	6 months[6] (minimum age 4 years for final dose).	
Measles, mumps, rubella[8]	12 months	4 weeks			
Varicella[9]	12 months	3 months			
Hepatitis A[10]	12 months	6 months			
Meningococcal[11] (MenACWY-D ≥9 mos; MenACWY-CRM ≥2 mos)	6 weeks	8 weeks[11]	See footnote 11	See footnote 11	
Children and adolescents age 7 through 18 years					
Meningococcal[11] (MenACWY-D ≥9 mos; MenACWY-CRM ≥2 mos)	Not Applicable (N/A)	8 weeks[11]			
Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis[13]	7 years[13]	4 weeks	4 weeks if first dose of DTaP/DT was administered before the 1st birthday. 6 months (as final dose) if first dose of DTaP/DT or Tdap/Td was administered at or after the 1st birthday.	6 months if first dose of DTaP/DT was administered before the 1st birthday.	
Human papillomavirus[14]	9 years	Routine dosing intervals are recommended.[14]			
Hepatitis A[10]	N/A	6 months			
Hepatitis B[1]	N/A	4 weeks	8 weeks **and** at least 16 weeks after first dose.		
Inactivated poliovirus[6]	N/A	4 weeks	6 months[6] A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.	A fourth dose of IPV is indicated if all previous doses were administered at <4 years or if the third dose was administered <6 months after the second dose.	
Measles, mumps, rubella[8]	N/A	4 weeks			
Varicella[9]	N/A	3 months if younger than age 13 years. 4 weeks if age 13 years or older.			

NOTE: The above recommendations must be read along with the footnotes of this schedule.

Figure 3. Vaccines that might be indicated for children and adolescents aged 18 years or younger based on medical indications

VACCINE ▼ INDICATION ▶	Pregnancy	Immunocompromised status (excluding HIV infection)	HIV infection CD4+ count[†] <15% or total CD4 cell count of <200/mm^3	HIV infection CD4+ count[†] ≥15% or total CD4 cell count of ≥200/mm^3	Kidney failure, end-stage renal disease, on hemodialysis	Heart disease, chronic lung disease	CSF leaks/ cochlear implants	Asplenia and persistent complement component deficiencies	Chronic liver disease	Diabetes
Hepatitis B[1]										
Rotavirus[2]		SCID*								
Diphtheria, tetanus, & acellular pertussis[3] (DTaP)										
Haemophilus influenzae type b[4]										
Pneumococcal conjugate[5]										
Inactivated poliovirus[6]										
Influenza[7]										
Measles, mumps, rubella[8]										
Varicella[9]										
Hepatitis A[10]										
Meningococcal ACWY[11]										
Tetanus, diphtheria, & acellular pertussis[13] (Tdap)										
Human papillomavirus[14]										
Meningococcal B[12]										
Pneumococcal polysaccharide[5]										

Vaccination according to the routine schedule recommended

Recommended for persons with an additional risk factor for which the vaccine would be indicated

Vaccination is recommended, and additional doses may be necessary based on medical condition. See footnotes.

No recommendation

Contraindicated

Precaution for vaccination

*Severe Combined Immunodeficiency

[†]For additional information regarding HIV laboratory parameters and use of live vaccines; see the General Best Practice Guidelines for Immunization "Altered Immunocompetence" at: www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html; and Table 4-1 (footnote D) at: www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.

NOTE: The above recommendations must be read along with the footnotes of this schedule.

Legal Definitions

Emergency Medical Condition – a sudden beginning of a medical condition showing itself by acute symptoms of enough severity (including severe pain) so that a careful layperson, with an average knowledge of health and medicine, could reasonably expect not having immediate medical attention to result in:

a) serious danger to the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child);
b) serious damage to bodily functions; or c. serious dysfunction of any bodily organ or part.

Long-term Care – personal and medical care in a nursing home, intermediate care facility for individuals with intellectual disabilities (ICF-IID), or Home and Community Based Services (HCBS) waiver program that TennCare pays for, including CHOICES and Employment and Community First CHOICES. People on TennCare must qualify to receive TennCare reimbursed long-term care.

Medically Necessary – to be medically necessary, a medical item or service must satisfy each of the following criteria:

a) It must be recommended by a licensed physician who is treating the enrollee or other licensed health care provider practicing within the scope of his or her license who is treating the enrollee;
b) It must be required in order to diagnose or treat an enrollee's medical condition;
c) It must be safe and effective;
d) It must not be experimental or investigational; and
e) It must be the least costly alternative course of diagnosis or treatment that is adequate for the enrollee's medical condition.

When applied to the care of the inpatient, it further means that the enrollee's medical condition requires that services cannot be safely provided to the enrollee as an outpatient;

When applied to enrollees under age 21, services shall be provided to meet the requirements of 42 CFR Part 441, Subpart B, and OBRA of 1989.

Glossary

Appeal: When your TennCare health plan says you don't qualify for a service, you will get a letter that says why. The letter you get is called a "Notice of Adverse Benefit Determination." If you think your TennCare health plan made a mistake, and if you think that you *do* qualify for the service, you can file an Appeal with TennCare. The letter will tell you how. An "Appeal" is a request for TennCare to give you a fair hearing. At your fair hearing, a judge will decide if your TennCare health plan made a mistake.

Copayments or Co-pays: A charge or fee that is due when a covered service is provided.

Durable Medical Equipment (DME): Medical equipment ordered by a doctor to help with a disability, illness, or injury. For example, oxygen equipment, wheelchairs, or crutches are types of DME.

Emergency Medical Condition: The sudden onset of an illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid serious harm.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services received in an emergency room.

Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services: Services that your TennCare health plan doesn't pay for or cover.

Grievance: A complaint you make about your TennCare health plan that involves anything other than an adverse benefit determination.

Habilitation Services and Devices: Services or equipment that help a person keep, learn, or improve skills and functioning for daily living. These services may include physical therapy, occupational therapy, speech therapy, and other services.

Health Insurance: A contract that requires a health insurer to pay for some or all of your health care in exchange for you (or your employer) paying an agreed amount each month, or each year. The amount you pay is called your "premium." Medicare, TennCare, TRICARE, and COBRA are also considered to be "health insurance."

Home Health Care: Health care services a person receives at home from nurses or home health aides.

Hospice Services: Services to relieve pain and provide support for persons in the last stages of a terminal illness.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

Medically Necessary: Health care services needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms. To be medically necessary, these services must meet TennCare requirements.

Network: The facilities, providers, and suppliers your TennCare health plan has contracted with to provide health care services.

Nonparticipating Provider: A health care provider that is not in your TennCare health plan's network. Also called an out-of-network provider.

Participating Provider: A health care provider in your TennCare health plan's network. Also called an in-network provider.

Physician Services: Health care services that are provided or coordinated by a licensed medical physician.

Plan: Your TennCare Pharmacy Benefit Manager, Dental Benefit Manager, or Managed Care Organization.

Preauthorization: A decision by your TennCare health plan that a service or prescription drug or is medically necessary for you. Sometimes called prior authorization, prior approval or precertification. Your TennCare health plan may require preauthorization before you can get certain services, supplies, or medications, except in an emergency.

Premium: The amount that must be paid for health insurance.

Prescription Drug Coverage: Health plan that helps pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that by law require a prescription.

Primary Care physician or Primary Care Provider (PCP): Your primary care provider is the doctor or other health care provider you see first for most health problems. He or she makes sure you get the care you need to stay healthy. He or she also may talk with other doctors and providers about your care and refer you to them. Usually, you must see your primary care provider before you see any other health care provider.

Provider: Any doctor, hospital, agency, or other person who has a license or is approved to deliver health care services. A provider may also be a clinic, pharmacy, or facility.

Rehabilitation Services: Health care services that help you recover from an illness, accident, or major operation. These services may include physical therapy, occupational therapy, speech-language pathology, and psychiatric rehabilitation services.

Skilled Nursing Care: Certain skilled services that can only be performed by licensed nurses in your home or in a nursing home.

Specialist: A physician who provides health care for a specific disease or part of the body. In order to see a specialist, TennCare members need to get a referral from their primary care provider.

Urgent Care: Care for an illness, injury or condition that is not an emergency but needs care right away.

Appendix A: Employment and Community First CHOICES Benefit Table

Service	How it can help you	What benefit groups cover it?			Limits
		Essential Family Supports (Group 4)	**Essential Supports for Employment and Independent Living (Group 5)**	**Comprehensive Supports for Employment and Community Living (Group 6)**	
Employment Supports					
--Individual Employment Supports					
Exploration	Helps you decide if you want to work and the kinds of jobs you might like and be really good at by visiting job sites that match your skills and interests. Also helps you (and your family) understand the benefits of working and helps answer your questions about work.	✔	✔	✔	No more than once a year (at least 365 days between services) **and** only if you're not employed or getting other employment supports **and** haven't decided if you want to work
Discovery	Someone to help you identify the kinds of work you want to do, the skills and strengths you will bring to your work, and what you need to be successful. This information can be used to help you write a plan to get a job or start your own business.	✔	✔	✔	No more than once every 3 years **and** only if you're not employed or getting other employment supports **and** have a goal to get a job within 12 months
Situational Observation and Assessment	A chance to try out certain jobs to see what they're like and what you need to do to get ready for those jobs	✔	✔	✔	No more than once every 3 years **and** only if you're not employed or getting other employment supports **and** have a goal to get a job within 12 months
Job Development Plan or Self-Employment Plan	Someone to help you write a plan to get a job (or start your own business)	✔	✔	✔	No more than once every 3 years **and** only if you're not employed or getting other employment supports **and** have a goal to get a job within 12 months

<table>
<tr><th>Service</th><th>How it can help you</th><th colspan="3">What benefit groups cover it?</th><th>Limits</th></tr>
<tr><td></td><td></td><td>Essential Family Supports (Group 4)</td><td>Essential Supports for Employment and Independent Living (Group 5)</td><td>Comprehensive Supports for Employment and Community Living (Group 6)</td><td></td></tr>
<tr><td colspan="2">--Individual Employment Supports</td><td colspan="4"></td></tr>
<tr><td>Job Development or Self-Employment Start Up</td><td>Someone to help you carry out your plan to get a job (or start your own business)</td><td>✓</td><td>✓</td><td>✓</td><td>No more than once a year (at least 365 days between services) and only if you’re not employed or getting other employment supports and have a goal to get a job within 9 months</td></tr>
<tr><td>Job Coaching</td><td>A job coach to support you when you start your job until you can do the job by yourself or with help from co-workers</td><td>✓</td><td>✓</td><td>✓</td><td rowspan="3">• Up to 40 hours per week of Job Coaching or Co-Worker Supports, Community Integration Support Services, Independent Living Skills Training <u>and</u> the hours you work combined <u>if</u> you work in the community or you’re self-employed in a community business
• Up to 50 hours per week of these services and the hours you work combined <u>if</u> you work in the community or you’re self-employed in a community business at least 30 hours per week</td></tr>
<tr><td>Job Coaching for Self-Employment</td><td>A job coach to support you when you start your business until you run the business by yourself</td><td>✓</td><td>✓</td><td>✓</td></tr>
<tr><td>Co-Worker Supports</td><td>Paying a co-worker to help you on your job instead of a job coach</td><td>✓</td><td>✓</td><td>✓</td></tr>
<tr><td>Career Advancement</td><td>Services to help you get a better job, earning more money</td><td>✓</td><td>✓</td><td>✓</td><td>No more than once every 3 years to get a promotion or second job</td></tr>
<tr><td>Benefits Counseling</td><td>Someone to help you understand how the money you earn from working will impact other benefits you get, including Social Security and TennCare</td><td>✓</td><td>✓</td><td>✓</td><td>• Only if you can’t get the service through another program
• Initial counseling up to 20 hours no more than once every 2 years
• Up to 6 more hours no more than 3 times a year to consider a new job, promotion, or self-employment</td></tr>
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Service	How it can help you	What benefit groups cover it?			Limits
					• Up to 8 extra hours 4 times a year to help you stay employed or self-employed
		Essential Family Supports (Group 4)	Essential Supports for Employment and Independent Living (Group 5)	Comprehensive Supports for Employment and Community Living (Group 6)	
--Small Group Employment Supports					
Supported Employment – Small Group	Support for you and 1 or 2 other people to work together in a small group. Helps you get ready for a job where you can work by yourself	✔	✔	✔	Up to 30 hours per week of Supported Employment– Small Group, Community Integration Support Services, and Independent Living Skills Training **combined**
--Pre-Vocational Training					
Integrated Employment Path Services	Time-limited training to get you ready for work in the community	✔	✔	✔	• Up to 12 months; may get up to 12 more months if actively working to get a job • Up to 30 hours per week of Integrated Employment Path Services or Supported Employment– Small Group, Community Integration Support Services, and Independent Living Skills Training **combined**

Service	How it can help you	What benefit groups cover it?			Limits
		Essential Family Supports (Group 4)	Essential Supports for Employment and Independent Living (Group 5)	Comprehensive Supports for Employment and Community Living (Group 6)	
Independent Community Living Supports					
Community Integration	Helps you do things in the community that you want to do. Take a class, join a club,	✔	✔	✔	

Support Services	volunteer, get or stay healthy, do something fun, build relationships, and reach your goals.				• Not covered as a separate service if you get Community Living Supports (it's part of that benefit) • **If you <u>don't</u> work in the community OR get an employment service:** Up to 20 hours per week of Community Integration Support Services and Independent Living Skills Training combined *after* agreeing to complete an Employment Informed Choice process • **If you <u>do</u> work in the community OR get an employment service:** Up to 30 hours per week of Community Integration Support Services, Independent Living Skills Training, and Individual or Small Group Employment Supports combined • **If you're working (in an individual job, not a group, in the community) or self-employed:** Up to 40 hours per week of Community Integration Support Services, Independent Living Skills Training, Job Coaching, Co-Worker Supports and the hours you work **combined** • **If you're working or self-employed in the community at least 30 hours a week:** Up to 50 hours per week of these services and the hours you work **combined**
Independent Living Skills Training	Helps you learn new things so you can live more independently. These skills can help you take care of yourself, your home, or your money.	✓	✓	✓	
Service	**How it can help you**	**What benefit groups cover it?**			**Limits**
		Essential Family Supports (Group 4)	**Essential Supports for Employment and Independent Living (Group 5)**	**Comprehensive Supports for Employment and Community Living (Group 6)**	

Independent Community Living Supports (Continued)					
Community Transportation	Helps you get to work or to other places in the community when public transportation isn't available and you don't have any other way to get there.	✓	✓	✓	Up to $225 per month if you to get this service through consumer direction
Personal Assistance	Someone to help with personal care needs or daily living activities in your home, at work, or in the community. Includes help with your household chores or errands. They can help you do things like get out of bed, take a bath, and get dressed so that you are ready to go to work or out into the community. They can also help you with **your** household chores (but not other people you live with). This includes things like **your** cleaning and laundry, help you fix and eat **your** meals, and run **your** errands. And, they can support you in the community to do the things you want to do. Also includes help training someone you know to provide this kind of support.		✓	✓	Up to 215 hours per month
Service	**How it can help you**	**What benefit groups cover it?**			**Limits**
		Essential Family Supports (Group 4)	**Essential Supports for Employment and Independent Living (Group 5)**	**Comprehensive Supports for Employment and Community Living (Group 6)**	

Service	How it can help you	What benefit groups cover it?			Limits
		Essential Family Supports (Group 4)	**Essential Supports for Employment and Independent Living (Group 5)**	**Comprehensive Supports for Employment and Community Living (Group 6)**	
Independent Community Living Supports (Continued)					
Assistive Technology, Adaptive Equipment and Supplies	Certain items that help you do things more independently in your home or community. This includes assessments and training on how to use them.	✔	✔	✔	Up to $5,000 per calendar year (January 1 – December 31 each year)
Minor Home Modifications	Certain changes to your home that will help you get around easier and safer in your home like grab bars or a wheelchair ramp.	✔	✔	✔	Up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime
Community Living Supports and Community Living Supports– Family Model	Support with activities of daily living and other tasks that help you live in the community and engage in community life. Usually in a small shared living arrangement or with a family (but not your own) who will provide the supports you need. You must pay for your room and board.		✔	✔	
Family Caregiving Supports					
Respite	Someone to support you for a short time so your caregiver can have a break. (Only for routine family or other caregivers who aren't paid to support you.)	✔	✔	✔	Up to 30 days per calendar year **<u>or</u>** 216 hours per calendar year (January 1 – December 31 each year). You have to **pick one**. You can ***only*** get hourly respite in Consumer Direction.

Family Caregiving Supports (Continued)					
Supportive Home Care	This is like Personal Assistance, but for people who live at home with their family. Someone to help you with personal care needs or daily living activities that your family can't help you with. This help could be in your home, on the job, or in the community. Includes help with your household chores or errands. They can help you do things like get out of bed, take a bath, and get dressed so that you are ready to go to work or out into the community. They can help you with **your** household chores (but not the whole family). This includes things like **your** cleaning and laundry, help you fix and eat **your** meals, and run **your** errands. They can also support you in the community to do the things you want to do.	✓			
Service	**How it can help you**	**What benefit groups cover it?**			**Limits**
		Essential Family Supports (Group 4)	**Essential Supports for Employment and Independent Living (Group 5)**	**Comprehensive Supports for Employment and Community Living (Group 6)**	

Family Caregiving Supports (Continued)					
Family Caregiver Stipend (instead of Supportive Home Care)	A monthly payment to your primary caregiver if they help with your personal care needs and daily living activities (instead of receiving Supportive Home Care). This payment helps offset lost wages or pays for things you need that aren't covered in Employment and Community First CHOICES. (But you **must** get the services you need to work and be part of your community.)	✓			• **Only if** you get the services you need to work and be part of the community • Up to $500 per month for children up to age 18 • Up to $1,000 per month for 18 years old and older
Self-Advocacy Supports					
Individual Education and Training	Help paying for workshops and training that will help you learn to advocate for yourself and direct your planning and supports.		✓	✓	Up to $500 per calendar year (January 1 – December 31 each year)
Peer-to-Peer Support and Navigation for Person-Centered Planning, Self-Direction, Integrated Individual/Self-Employment & Independent Community Living	Guidance and support from another person with disabilities who has experience and training to answer your questions and help you: - Direct your support plan. - Direct your services (hire and supervise your own staff in Consumer Direction). - Think about and try employment or community living options.		✓	✓	Up to $1,500 per lifetime
Service	**How it can help you**	**What benefit groups cover it?**			**Limits**
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Self-Advocacy Supports (Continued)					
Conservatorship and Alternatives to Conservatorship Counseling and Assistance	Help understanding options to protect the rights and freedom of adults with disabilities, while providing the support they need to make decisions. Can include help paying for legal or court fees for these options but you have to get the counseling service first.	✓	✓	✓	• Up to $500 per lifetime • Must get counseling service **first**
Family Empowerment Supports					
Community Support Development, Organization and Navigation	Helps you and other people with disabilities and their families: - Connect with and help each other, and - Find and use resources in your community.	✓			
Family Caregiver Education and Training	Help paying for workshops and training that will help family caregivers understand, support and advocate for you and help you advocate for yourself.	✓			Up to $500 per calendar year (January 1 – December 31 each year)
Family to Family Support	Guidance and support from another parent of a person with disabilities who has experience and training.	✓			

Family Empowerment Supports (Continued)					
Health Insurance Counseling/ Forms Assistance	Training and support to help you understand and use your insurance benefits (including TennCare, Medicare and private insurance).	✓			Up to 15 hours per calendar year (January 1 – December 31 each year)
Dental and Therapy Supports					
Adult Dental Services	Basic dental care for adults age 21 and older, including dental exams, cleanings, and fillings. (Children under age 21 already have dental care through TennCare.)	✓	✓	✓	• Up to $5,000 per calendar year (January 1 – December 31 each year) • No more than $7,500 for three calendar years in a row
Specialized Consultation and Training	Help from a professional to assess, plan and teach others to support you, including paid staff and unpaid caregivers. Kinds of professional help and training include: - Behavior services - Speech therapy - Occupational therapy - Physical therapy - Nutrition - Orientation and mobility - Nursing		✓	✓	• Up to $5,000 per calendar year (January 1 – December 31 each year) • Up to $10,000 if your assessment shows you have exceptional medical and/or behavioral health needs