handbook

BlueCare Member Guide | 2026

BlueCare Tennessee | BlueCare℠

FREE Phone Numbers to call for help

FREE Phone Numbers to call for help

BlueCare Call about your health care	**800-468-9698**
BlueCare CHOICES in Long-Term Services and Support Call to apply for CHOICES or speak to your Care Coordinator	**800-468-9698**
BlueCare Employment and Community First (ECF) CHOICES Call if you need help to complete a self-referral or to speak to your Support Coordinator	**800-468-9698**
Nurse Help Line	**1-800-262-2873**
Renaissance (TennCare Dental Program) Call about dental (teeth) care	**866-864-2526**
OptumRx (TennCare Pharmacy Program) Call about TennCare pharmacy services	**888-816-1680**
TennCare Connect Call about: • Change of address, family size, job, or income • When you're pregnant and when your baby is born • Completing your renewal • Appeals to get or keep TennCare • TennCare co-pays • Applying for TennCare • Programs like Food Stamps or Families First	**855-259-0701**
TennCare Advocacy Program Call for help with physical health services or help with Behavioral Health Services (mental health, alcohol, and substance use disorder services)	**800-758-1638** TTY/TDD Line: **877-779-3103**
TennCare Member Medical Appeals	**800-878-3192**

Call to file appeals like: • When you have problems getting health care • When you are denied a service you requested • When a service you were receiving is being terminated or reduced • When you want to change your health plan (MCO) • When you want to be paid back for expenses you think BlueCare should have paid • When you got billed by a provider for a benefit you think BlueCare should pay	TTY/TDD Line: **866-771-7043**
Medicare Information and Assistance Line Call about Medicare	**800-633-4227**
State Health Insurance Assistance Program (SHIP) Help Line Call for help with Medicare	**877-801-0044**
Social Security Administration Call about Social Security and Disability	**800-772-1213**
Office of Inspector General (OIG) Call to report TennCare member fraud or abuse	**800-433-3982**
TennCare Office of Program Integrity Call to report TennCare provider fraud	**833-687-9611**
Transportation Services Call for a ride to get to your health care visit if you don't have a way to get there	**1-866-473-7565**
Community Resources Visit Tennessee Community Compass for help with connecting to food banks, housing services, and other life needs.	**800-468-9698** **communitycompass.tn.gov/**

Doctor's Names	**Phone Numbers**

TennCare and your health plan BlueCare

Member Handbook 2026

¿Necesita un manual de TennCare en español? Para conseguir un manual en español, llame a **BlueCare** al **800-468-9698.**

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 TennCare Connect for free at **855-259-0701.**

Do you need help?

We have free auxiliary aids and services, like large print, to communicate effectively with you. Call us at 800-468-9698 (TRS: 711). If you speak a language other than English, help in your language is available for free. We have free interpretation and translation services to help you.

Spanish: Español

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-468-9698 (TRS/TTY:866-503-0264).

Arabic: العربية

ملحوظة: اذا تتكلم اللغة العربية خدمات المساعدة اللغوية متوفرة لك مجانا. اتصل برقم 800-468-9698

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 800-468-9698

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 800-468-9698

Korean: 한국어

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-468-9698 번으로 전화해 주십시오.

French: Français

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-468-9698.

Amharic: አማርኛ

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-468-9698.

Gujarati: ગુજરાતી

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 800-468-9698.

Laotian: ພາສາລາວ

ໂປດ ຊາບ: ຖ້າ ວ່າ ທ່ານ ເວົ້າ ພາ ສາ ລາວ, ການ ບໍ ລິ ການ ຊ່ວຍ ເຫຼືອ ດ້ານ ພາ ສາ, ໂດຍ ບໍ່ ເສັ ຽ ຄ່າ, ແມ່ນ ມີ ພ້ອມ ໃຫ້ ທ່ານ. ໂທ ຣ 800-468-9698.

German: Deutsch

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-468-9698 .

Tagalog: Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-468-9698.

Hindi: हिंदी

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 800-468-9698 पर कॉल करें।

Russian: Русский

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-468-9698 .

Japanese: 日本語

「日本語を話す方は、通訳や翻訳などの言語支援サービスを無料で利用できます」

Persian: فارسی

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-468-9698 تماس بگیرید.

The Beneficiary Support System (BSS) helps people who are enrolled in the CHOICES, Employment and Community First (ECF) CHOICES, and the Katie Beckett program. They also help people who want to enroll into these programs. For help call 888-723-8193.

The TennCare Program does not discriminate against people because of their race, color, national origin including limited English proficiency and primary language, age, disability, religion, or sex. If you need reasonable modifications or think you were treated differently or discriminated against you can file a grievance (complaint) with TennCare's Office of Civil Rights Compliance at:

Email: HCFA.fairtreatment@tn.gov
Website: https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html
Mail: 310 Great Circle Road Floor 3W, Nashville, TN 37243
Phone: 615-507-6474 (TRS 711).

Need help filing a grievance? Call TennCare Connect at 855-259-0701.

Notice of Nondiscrimination

Protections

Discrimination is against the law. TennCare obeys federal and state civil rights laws. We don't discriminate on the basis of race, color, national origin including limited English proficiency and primary language, age, disability, or sex. TennCare doesn't exclude people or treat them less favorably (differently) because of race, color, national origin, age, disability, or sex.

Help You Can Get

Disability Related Help

TennCare provides people with disabilities reasonable modifications. Reasonable modifications are reasonable requests for changes to a rule, policy, practice, or service to help a person with a disability related need. TennCare has free auxiliary aids and services to communicate effectively with you. Auxiliary aids and services are types of help like:

- Qualified sign language interpreters and
- Written information in large print, audio, accessible electronic formats, letter reading, Braille, or other formats.

Language Help

TennCare offers free language help to people whose primary language is not English like:

- Qualified interpreters and
- Translations - Information written in other languages.

Who to Contact

TennCare Connect

Do you need help like applying or renewing your TennCare, need auxiliary aids and services, or language help to talk with TennCare? Call TennCare Connect for free at 855-259-0701.

TennCare's Office of Civil Rights Compliance

- Reasonable Modifications
  If you need reasonable modifications, contact TennCare's Office of Civil Rights Compliance ("OCRC").
- Grievance/Complaint

If you believe that TennCare failed to provide these services, or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance/complaint with TennCare's OCRC by:

- Email: HCFA.fairtreatment@tn.gov,
- Mail:
  310 Great Circle Road Floor 3W
  Nashville, TN 37243,
- Online: OCRC's website at https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html,
- Phone: 615-507-6474 (TRS 711)

If you need help filing a grievance call TennCare Connect for free at 855-259-0701.

More Information

You can find forms, policies and more information about civil rights and help like for food or other things on OCRC's website: https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html.

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

- Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail:
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201
- By phone: 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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Welcome to TennCare and your health plan, BlueCare

This is your TennCare member handbook. This handbook tells you how 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

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.

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.

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 TennCare Connect for free at **855-259-0701.**

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 TennCare Connect right away if:

- You move**
- The number of people in your family changes
- You change jobs
- 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 TennCare Connect at **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 TennCare Connect **or** Social Security, call us at **800-468-9698** and tell us your new address too.

Your TennCare Health Plan

BlueCare is your TennCare health plan that helps you get **physical or behavioral health care (mental health and substance use disorder 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 **800-468-9698.** It's a free call. You can also call us for help with CHOICES or Employment and Community First CHOICES.

Do you have questions about your health? Do you need to know what kind of doctor you should see? Call our Nurse Help Line at **1-800-262-2873.** It's a free call.

Do you need to change your health plan?

Is BlueCare the health plan that you asked for? If you need or want to change your health plan, you have 90 days from the day you got your TennCare letter. To change your health plan in the first 90 days, call TennCare Member Medical Appeals at **800-878-3192** for free. Tell them you just got your TennCare and you want to change your health plan.

After 90 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 90 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 **800-468-9698** 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 care, you'll have to get a new OK from your new plan.

Your 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 **OptumRx.** You should have an OptumRx pharmacy card. What if you don't have a pharmacy card? You can download one online at www.optumrx.com or call **888-816-1680.**

You can also tell your pharmacy that you have TennCare.

Make sure the pharmacy you use accepts TennCare.

To find out if a pharmacy accepts TennCare, go to https://www.optumrx.com/oe_tenncare/find-a-network-pharmacy

Or, you can call the TennCare pharmacy help desk at **888-816-1680.**

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

Continuous Glucose Monitors and Related Supplies

TennCare members can access continuous glucose monitors (CGMs) and related supplies through the pharmacy health plan OR medical health plan. Under the pharmacy health plan, prescriptions for CGMs and related supplies may be sent to your in-network pharmacy of choice by your medical provider.

Your Dental Health Plan

TennCare's dental health plan is Renaissance. Renaissance will manage the dental benefits for all TennCare members. Regular oral checkups are important to your overall health. Dental services like dental cleaning, x-rays, and other dental benefits are covered with limits.

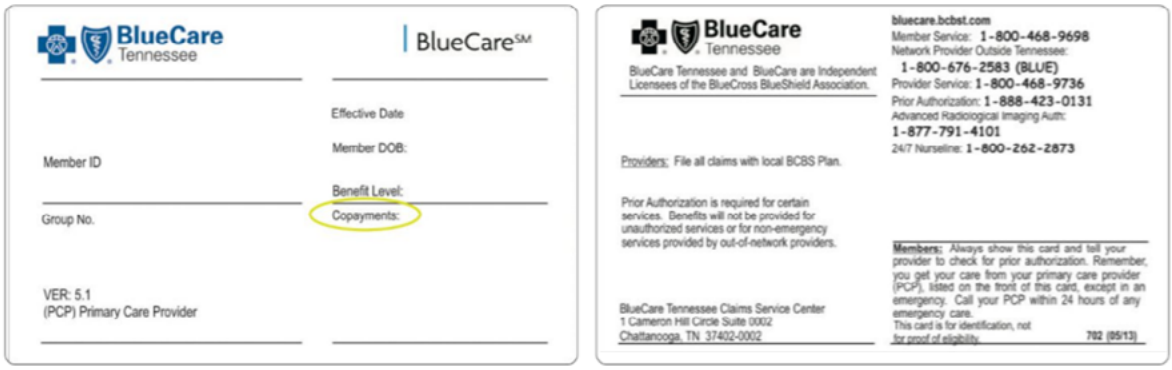
They can help you if you have questions about dental care. To find a Renaissance dentist, go to https://www.renmemberportal.com/mp/rengp. Then click **Find a Dentist.** Or you can call them at **866-864-2526.**

Learn more about dental coverage in the Renaissance Handbook.

Part 1: Using your TennCare Health Plan

Your Member Card

Every BlueCare member has a Member Card. This is an example of what your card looks like:



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.
- **Group 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 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 **800-468-9698** for a new card. It's a free call.

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

Call Us:

800-468-9698

Write to us:

BlueCare Claims Service Center

1 Cameron Hill Circle, Suite 0002

Chattanooga, TN 37402

BlueCare Provider Network

In Network

The doctors and other people and places who work with BlueCare 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 **bluecare.bcbst.com.** Or call us at **800-468-9698** 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 **800-468-9698** to find out if a provider is in our network.

Sometimes your provider can't give you the care or treatment you need because of their personal beliefs. Call us at **800-468-9698.** We can help you find a provider who can give you the care or treatment you need. Or you can use the Find Care tool at **bluecare.bcbst.com**.

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

But if you also have Medicare, you **don't** have to use doctors who take BlueCare. 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 BlueCare 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.

Important: 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 **800-468-9698** 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. Or you can use the Find Care tool at bluecare.bcbst.com.

You can also get free help to communicate with your doctor like a sign language interpreter, writing notes, or a story board. **Before your appointment, call us or your provider** to get this help.

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 or 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, call Verida at **855-735-4660** or go to **member.verida.com**. If you're a minor riding alone or you're traveling out of state, or if you have questions about having someone ride with you, call us at **800-468-9698**.

Try to call **at least two business days 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 800-468-9698 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 **1-800-262-2873.**

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 won't 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 BlueCare card ready when you call.
4. Say you are a BlueCare 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 two business days before your appointment. Page 19 and Part 5 of this handbook tell you more about getting a ride.

On the day of your appointment:

1. Take all your medicine and a list of questions with you so your PCP will know how to help you.
2. Be on time for your visit. If you can't keep your appointment, call your PCP to get a new time.
3. Take your BlueCare 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 healthcare picture. Your PCP keeps track of all of the care you get.

Changing your PCP

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 BlueCare, 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 BlueCare network. To find a new PCP you can look in our Provider Directory, you can go online at **bluecare.bcbst.com,** or call **800-468-9698.**
2. Then call the new PCP to make sure that he or she is in the BlueCare 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 **800-468-9698** to tell us the name of your new PCP.

Need help finding a new PCP? Call us at 800-468-9698. 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 BlueCare 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 must 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 Care (Mental Health or Substance Use Disorder 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 BlueCare.

A Community Mental Health Agency (CMHA) is one place you can go for mental health or substance use disorder 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 BlueCare card ready when you call to schedule your appointment with your new provider.
3. Say you are a BlueCare 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.
8. Make a list of questions you want to ask your provider. List any problems you have.
9. 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 two business days** before your visit. Page 19 and 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 provider will know how to help you.
2. Be on time for your visit. If you can't keep your appointment, call your provider to get a new time.
3. Take your BlueCare 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 of this handbook.

If you need help finding mental health and substance use disorder services, call us at **800-468-9698.** Or, if you have questions about mental health and substance use disorder services, call us at **800-468-9698.** It's a free call.

Specialists

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 use disorder 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.

Physical Health Emergencies

Always carry your BlueCare 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 • A bad cut, broken bone, or a burn • Bleeding that cannot be stopped • Strong chest pain that does not go away • Strong stomach pain that doesn't stop • Seizures that cause someone to pass out • Not able to move your legs or arms • A person who will not wake up • Drug overdose	• Sore throat • Cold or flu • Lower back pain • Earache • Stomachache • Small, not deep, cuts • Bruise • Headache, unless it is very bad and like you've never had before • 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 mental health or substance use disorder 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 mental health or substance use disorder emergency, call or text 988 or chat with 988lifeline.org. You can also go to the nearest mental health crisis walk-in center (https://www.tn.gov/behavioral-health/need-help/crisis-services/walk-in-centers.html) **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 988 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:

- Planning to hurt yourself
- Thinking about hurting another person

These are usually not emergencies:

- Needing a prescription refill
- Feelings of depression or anxiety without being a danger to yourself or others.

If you have this kind of emergency:

- Call or text 988 or chat with 988lifeline.org
- Go to the nearest mental health crisis walk-in center or ER right away or
- Or call 911. 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 or substance use disorder) emergency:

- Call or text 988 or chat with 988lifeline.org
- Go to the nearest ER
- Call 911 or

To reach an agency directly:

- Youth Villages
    - (866) 791-9221 (North Middle TN)
    - (866) 791-9222 (South Middle TN)

    - (866) 791-9227 (Rural West TN)
    - (866) 791-9226 (Memphis Region)
    - (866) 791-9224 (East Region)
    - (866) 791-9225 (Southeast Region)

- Mental Health Cooperative
    - (615) 726-0125 (Davidson County)

- Frontier Health
    - (877) 928-9062 (Upper East TN)

- McNabb Center
    - (865) 539-2409 (East TN)

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 **800-468-9698.** We will help you. You can also call 911. These calls are free.

Always carry your BlueCare 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 mental health, alcohol or drug abuse emergency, you can call or text **988** or chat with **988lifeline.org**. You must still call your PCP and health plan within 24 hours of getting the emergency care away from home.

Show your BlueCare card when you get the emergency care. Ask the ER to send the bill to BlueCare. 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 **800-468-9698** 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 BlueCare 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

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 receive 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 **800-468-9698.**

Children under age 21

Go to pages 32 - 35 for the list of benefits groups A and H

Benefit Indicator	Description of Group
A	• Child under age 21, and • Does not have Medicare.
H	• Child under age 21, and • Has Medicare.

Adults aged 21 and older with TennCare Medicaid

Go to pages 35 - 39 for the list of benefits for groups B, E, J and L

Benefit Indicator	Description of Group
B	• Over age 21, and • Does not have Medicare, and • Is not getting long-term care.
E	• Over age 21, and • Does not have Medicare, and • Is getting long-term care other than CHOICES or ECF CHOICES.
J	• Over age 21, and • Does not have Medicare, and • Is enrolled in TennCare CHOICES Group 1 or 2 or ECF CHOICES* and meets institutional level of care.
L	• Over age 21, and • Does not have Medicare, and • Is enrolled in TennCare CHOICES Group 3 or ECF CHOICES* and

	does not meet institutional level of care but is at risk of institutional placement.

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

Adults aged 21 and older with TennCare Medicaid and Medicare

Go to pages 40 - 43 for the list of benefits for groups F, G, K and M.

Benefit Indicator	Description of Group
F	• Over age 21, and • Has Medicare, and • Is not getting long-term care.
G	• Over age 21, and • Has Medicare, and • Is getting long-term care other than CHOICES or ECF CHOICES.
K	• Over age 21, and • Has Medicare, and • Is enrolled in TennCare CHOICES Group 1 or 2 or ECF CHOICES* and meets institutional level of care.
M	• Over age 21, and • Has Medicare, and • Is enrolled in TennCare CHOICES Group 3 or ECF CHOICES* and does not meet institutional level of care but is at risk of institutional placement.

*More information about TennCare CHOICES and Employment and Community First CHOICES can be found in Part 3 of this handbook.

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 **800-468-9698.** Or call TennCare Connect at **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:

https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-13.20240807.pdf

Benefit Packages A and H (Children under age 21)

TennCare Services	A	H
Behavioral health crisis services (mental health, and substance use disorder services)	Covered	Covered. This care is not covered by Medicare.
Behavioral Health Intensive Community Based Treatment	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.

TennCare Services	A	H
Dental services	Covered	Covered, but Medicare is primary.
Durable medical equipment (DME)	Covered	Covered, but Medicare is primary.
Early and 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.
Employment and Community First (ECF) CHOICES benefits **(Certain Home and Community Based Services)** **For more information, see Employment and Community First CHOICES in Part 3 of this handbook.**	Covered for members enrolled in ECF CHOICES only	Covered for members enrolled in ECF CHOICES only.
Home health services	Covered	Covered, but Medicare is primary.
Hospice care (Must be provided by a Medicare-Certified Hospice)	Covered	Covered, but Medicare is primary.
Inpatient, residential, and outpatient substance use disorder benefits	Covered	Covered, but Medicare is primary.
Inpatient hospital services	Covered	Covered, but Medicare is primary.
Inpatient rehabilitation facility 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.
Non-emergency transportation, including ambulance transportation	Covered	Covered, but Medicare is primary.

TennCare Services	A	H
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 and tissue transplants and donor organ procurements	Covered	Covered, but Medicare is primary.
Outpatient hospital services	Covered	Covered, but Medicare is primary.
Outpatient behavioral health services (mental health and substance use disorder 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 (inpatient and outpatient)	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.

TennCare Services	A	H
Reconstructive breast surgery (see Women's Health and Pregnancy for more information)	Covered	Covered, but Medicare is primary.
Renal dialysis services	Covered	Covered, but Medicare is primary.
Speech therapy services	Covered	Covered, but Medicare is primary. Must be provided by a licensed speech therapist to restore speech. There must be continued medical progress after a loss or impairment. Also, the loss or impairment can't be caused by a mental, psychoneurotic, or personality disorder.
Vision services	Covered	Covered, but Medicare is primary.

Benefits for adults aged 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:
https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-13.20240807.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 and substance use disorder services)	Covered	Covered	Covered	Covered
Behavioral Health Intensive Community Based Treatment	Covered	Covered	Covered	Covered
Chiropractic services	Covered	Covered	Covered	Covered
Community health clinic services	Covered	Covered	Covered	Covered
CHOICES benefits (Nursing Facility care and certain Home and Community Based Services, HCBS) **For more information, see CHOICES in Part 3 of this handbook**	Not Covered	Not Covered	Covered for individuals enrolled in CHOICES only	Covered for individuals enrolled in CHOICES Group3 only, and limited to Group 3 HCBS only. Nursing Facility care not covered.
Dental services	Covered with limits.	Covered with limits.	Covered, with limits.	Covered, with limits

Durable medical equipment (DME)	Covered	Covered	Covered	Covered
Emergency air and ground ambulance	Covered	Covered	Covered	Covered
Employment and Community First (ECF) CHOICES benefits **(Certain Home and Community Based Services)**	Not Covered	Not Covered	Covered for members enrolled in ECF CHOICES only	Covered for members enrolled in ECF CHOICES only
Home health services	Covered with limits. See "Care with limits" starting on page 46.	Covered with limits. See "Care with limits" starting on page 46.	Covered with limits. See "Care with limits" starting on page 46.	Covered with limits. See "Care with limits" starting on page 46.
Hospice care (Must be provided by a Medicare-Certified Hospice)	Covered	Covered	Covered	Covered
Inpatient and outpatient substance use disorder 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
Non-emergency transportation	Covered	Covered	Covered	Covered
Occupational therapy	Covered	Covered	Covered	Covered

Organ and tissue transplants and donor organ procurements	Covered	Covered	Covered	Covered
Outpatient hospital services	Covered	Covered	Covered	Covered
Outpatient behavioral health services (mental health and substance use disorder services)	Covered	Covered	Covered	Covered
Pharmacy services	Covered with limits. See "Care with limits" starting on page 46.	Covered – no limit	Covered – no limit	Covered with limits. See "Care with limits" starting on page 46.
Physical therapy services	Covered	Covered	Covered	Covered
Physician services (inpatient and outpatient)	Covered	Covered	Covered	Covered
Private duty nursing	Covered with limits. See "Care with limits" starting on page 46.	Covered with limits. See "Care with limits" starting on page 46.	Covered with limits. See "Care with limits" starting on page 46.	Covered with limits. See "Care with limits" starting on page 46.
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 (see Women's Health and Pregnancy for more information)	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 46.	Covered with limits. See "Care with limits" starting on page 46.	Covered with limits. See "Care with limits" starting on page 46.	Covered with limits. See "Care with limits" starting on page 46.

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 and substance use disorder 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
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
Chiropractic services	Covered Medicare is primary	Covered Medicare is primary	Covered Medicare is primary	Covered Medicare is primary
Community health clinic services	Covered Medicare is primary	Covered Medicare is primary	Covered Medicare is primary	Covered Medicare is primary
CHOICES benefits (Nursing Facility care and certain Home and Community Based Services, HCBS) **For more information, see CHOICES in Part 3 of this handbook.**	Not Covered	Not Covered	Covered. Medicare is primary for Skilled Nursing Facility care.	Covered for individuals enrolled in CHOICES Group 3 only, and limited to Group 3 HCBS only. Nursing Facility care not covered. Medicare covers Skilled Nursing Facility care.
Dental services	Covered with limits, but Medicare is primary	Covered with limits, but Medicare is primary	Covered with limits, but Medicare is primary	Covered with limits, but Medicare is primary
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
Employment and Community First (ECF) CHOICES benefits **(Certain Home and Community Based Services)** **For more information, see ECF CHOICES in Part 3 of this handbook.**	Not Covered	Not Covered	Covered for members enrolled in ECF CHOICES	Covered for members enrolled in ECF CHOICES only.
Home health services	Covered with limits. Medicare is primary. See "Care with limits" starting on page 46.	Covered with limits. Medicare is primary. See "Care with limits" starting on page 46.	Covered with limits. Medicare is primary. See "Care with limits" starting on page 46.	Covered with limits. Medicare is primary. See "Care with limits" starting on page 46.
Hospice care (Must be provided by a Medicare-Certified Hospice)	Covered Medicare is primary	Covered Medicare is primary	Covered Medicare is primary	Covered Medicare is primary
Inpatient and outpatient substance use disorder 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
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
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 and tissue transplants and donor organ procurements	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 and substance use disorder 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 (inpatient and outpatient)	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 limits”	Covered with limits. Medicare does not cover this care; See “Care with limits”	Covered with limits. Medicare does not cover this care; See “Care with limits”	Covered with limits Medicare does not cover this care; See “Care with limits” starting on page 46.

	starting on page 46.	starting on page 46.	starting on page 46.	
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 (see Women's Health and Pregnancy for more information)	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 46.	Covered with limits. Medicare is primary; See "Care with limits" starting on page 46.	Covered with limits. Medicare is primary; See "Care with limits" starting on page 46.	Covered with limits. Medicare is primary; See "Care with limits" starting on page 46.

Benefit Packages C and D (Adults age 21 and older with TennCare Standard)[1]

TennCare Services	C	D
Behavioral health crisis services (mental health and substance use disorder services)	Covered	Covered

Behavioral Health Intensive Community Based Treatment	Covered	Covered
Chiropractic services	Covered	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	Covered with limits	Covered with limits
Durable medical equipment (DME)	Covered	Covered
Emergency air and ground ambulance	Covered	Covered
Employment and Community First (ECF) CHOICES benefits **(Certain Home and Community Based Services)**	Not Covered	Not Covered
Home health services	Covered with limits. See "Care with limits" starting on page 46.	Covered with limits. See "Care with limits" starting on page 46.
Hospice care (Must be provided by a Medicare-Certified Hospice)	Covered	Covered
Inpatient and outpatient substance use disorder services	Covered	Covered
Inpatient hospital services	Covered	Covered
Lab and x-ray services	Covered	Covered
Medical supplies	Covered	Covered

Non-emergency transportation	Covered	Covered
Occupational therapy	Covered	Covered
Organ and tissue transplants and donor organ procurements	Covered	Covered
Outpatient hospital services	Covered	Covered
Outpatient behavioral health services (mental health and substance use disorder services)	Covered	Covered
Pharmacy services	Not Covered	Covered with limits. See “Care with limits” starting on page 46.
Physical therapy services	Covered	Covered
Physician services (inpatient and outpatient)	Covered	Covered
Private duty nursing	Covered with limits. See “Care with limits” starting on page 46.	Covered with limits. See “Care with limits” starting on page 46.
Psychiatric inpatient facility services	Covered	Covered
Psychiatric rehabilitation services	Covered	Covered
Psychiatric residential treatment services	Covered	Covered
Reconstructive breast surgery (see Women’s Health and Pregnancy for more information)	Covered	Covered
Renal dialysis services	Covered	Covered

Speech therapy services	Covered	Covered
Vision services	Covered with limits. See "Care with limits" starting on page 46.	Covered with limits. See "Care with limits" starting on page 46.

[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. This table is not applicable for adults in CHOICES and Employment and Community First CHOICES.

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**
8. **Dental Services**
9. **Inpatient or Residential Treatment for Substance Use Disorder Services**

1. Prescription Medicine

Most people, but not everyone on TennCare, have pharmacy benefits. If you also have Medicare, there's an important message for you in the box on 49.

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 facility 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 brand-name prescriptions TennCare will pay for each month. TennCare Medicaid will only pay for 2 brand-name prescriptions or refills each month. There is no limit on the number of generic prescriptions that TennCare will cover each month. TennCare will start counting your prescriptions and refills on the first day of each month. This limit includes prescriptions for physical health care.

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 2 brand-name prescriptions or refills each month?

There are lists of medicines that do not count against your limit. These lists are called the **Automatic Exemption Lists** (Drug stores call it the "Auto Exemption" and the "Prescriber Attestation" list)**.**

Medicines on these lists are exempt from (they don't count) against your limit. After you've gotten **2** brand name prescriptions in 1 month, you can still get medicines on the **Automatic Exemption Lists.** The lists may change. But, TennCare and your drug store will make sure that medicines on the most current lists **don't** count against your limit.

Do you need to find out if medicine you take is on these lists? **Ask** your doctor or drug store. To see the most current list, you can use the internet. Go to the OptumRx/TennCare website at **https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/AutoExempt-Attestation-Drug-List.pdf.** Or, call TennCare Connect at **855-259-0701.** Ask them to mail you a copy.

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 Automatic Exemption lists may need a **PA** too. If so, you'll need **both** OKs to get a medicine on the **Automatic Exemption Lists.** Your doctor can help you get both OKs if you need them.

What if a medicine on the Automatic Exemption Lists 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.

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 Automatic Exemption Lists.
- 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 **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 31st. 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 misused, like Lortab®, Kadian® (morphine), and OxyContin® . TennCare will only pay for **24 urine drug screenings per year** for adults age 21 and older.

Right now, TennCare pays for 24 urine drug tests per year. TennCare also pays for 12 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 12 times per year. **TennCare will keep paying for 24 urine drug tests and 12 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. **TennCare will only pay for 12 specific 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

Private Duty Nursing are 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 (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.

8. Dental Services

For adults age 21 and older, see your Dental Benefits Manager (DBM) Handbook for limits.

9. Inpatient or Residential Treatment Services for Substance Use Disorders

TennCare covers inpatient or residential substance use disorder treatment services. Treatment facilities with more than 16 beds are called Institutions for Mental Diseases, or "IMDs." For adults ages 21 through 64, substance use disorder treatment in IMD facilities is limited to 30 days per year.

In Lieu of Services

BlueCare offers certain services that are medically appropriate, cost-effective substitutions for services covered by TennCare. These are called "in lieu of services." BlueCare offers the following in lieu of services:

- Inpatient rehabilitation facility services

- Blood pressure cuffs for pregnant or postpartum women
- Additional treatment days, up to 15 days per month, for substance use disorder treatment services for adults ages 21 through 64 in Institutions for Mental Diseases (in addition to the 30 days per year covered by TennCare).

In lieu of services are covered when they are medically needed for you based on your health condition. For more information about in lieu of services, you can call BlueCare.

Other TennCare Services

1. 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.

2. 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 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.

3. Electronic Visit Verification (EVV)

Federal law says that any person who receives certain types of care paid for by Medicaid **MUST** use an electronic system to log the care they provide. This is called **EVV** (which stands for **E**lectronic **V**isit **V**erification). Some of the services like Home Health and Personal Care services must use EVV. **EVV** is a way to make sure you get the Medicaid services you are approved to get. The EVV system collects and records information every time your paid caregiver comes to give you care. The law says that an **EVV** system **MUST be used to record ALL of these things:**

- Your name (the name of the person who received care)
- The service you received
- Your worker (the name of the person who provided your care)
- The date you got the care
- Where the care was provided
- The time it started
- The time it ended

How will your paid caregivers use EVV?

Your Home Health and Personal Care Services provider will choose how your paid caregiver reports information. Reporting tools may include a mobile app on a smart phone or tablet. **Only** your paid caregiver should use the EVV system. This is not for you to do.

The main things you should know:

- Your services will not change
- Your care will not change
- The amount of care you receive will not change
- Your care will still be provided where you receive it now

Who can you talk with if you have questions?

If you have questions about EVV or the way your paid caregiver reports information, please call your Home Health and Personal Care Services provider.

4. Complex Rehabilitation Technology (Special gear for people with trouble moving around because of an injury or a disability)

BlueCare pays for special gear that helps people with injuries or disabilities move around better. This gear is called complex rehabilitation technology (CRT). It is a part of the durable medical equipment (DME) benefit. Tennessee law makes sure this gear is checked each year for any issues and gets fixed when it needs repairs.

Do you need to see a doctor in person to talk about your CRT, but can't because of an injury or disability? The law says that doctors have to offer you a video or phone call visit instead.

Do you have questions about CRT or need more information? Call <MCO – if you have phone number, insert here>.

5. Special Services

Some services are covered by TennCare **only in special cases.** These are services like:

- **Population Health**
- **Hospice Care**
- **Sterilization**
- **Abortion**
- **Hysterectomy**

More about these services can be found below.

Population Health

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

- Understand your illness and how to feel better
- Help you or your child find a primary care doctor and get to your appointments
- Develop a plan of care based on your doctor's or your child's doctor's advice for medical and behavioral health needs
- Partner with you to coordinate care with other health care providers
- Have a healthy pregnancy and healthy delivery
- Help with getting your prescription medications

- Help keep you or your child out of the hospital by getting care in the community
- Identify community organizations that can provide non-medical supports and resources to improve the health and well-being of you or your child
- Help you with lifestyle changes that you want to make like quitting smoking or managing your weight
- Help explain important health information to you or to your doctors

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 **BlueCare Population Health at 800-468-9698.**

Hospice Care

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 800-468-9698.

Sterilization

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 must fill this out with your provider.

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

Abortion may only be covered in limited cases, like if you have a physical illness that you could die from without an abortion.

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

Hysterectomy

A 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 for a covered reason and medically necessary.

You must be told in words and in writing that having a hysterectomy means you are not able to have children. You must sign a paper called Hysterectomy Acknowledgement Form.

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
- Don't drink alcohol or misuse drugs

- Eat right
- Exercise
- Take medicine just as your doctor says
- Do self-examinations
- Don't smoke
- 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
- Colon and rectal cancer
- Bone hardness (osteoporosis)
- Thyroid
- STDs (sexually transmitted diseases)
- Blood sugar
- 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 healthcare. 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:

- Your diagnosis
- Certain health care services you use

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

Dental Care for Adults (for teeth)

Dental care for adults age 21 and older is covered with limits. Dental care includes benefits like checkups, x-rays, oral treatments and more. See your Dental Benefits Manager (DBM) Handbook for limits.

Your dental plan for your teeth is called **Renaissance.** They can help you if you have questions about dental care. To find a dentist, you can call them at **866-864-2526.** It's a free call.

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 okay.

Mammography screening benefits are available:

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

If you have had breast cancer, surgery to restore a breast to near normal shape, appearance, and size (breast reconstructive surgery) after a mastectomy is covered. This includes reconstructive surgery for a cancerous breast and reconstructive surgery for a breast without cancer so that the breasts are the same size and shape (to make them symmetrical).

This surgery is covered as long as it is done within five years of the reconstructive surgery on the diseased breast.

You can get well-woman checkups from your PCP, or from a specialist called and 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 or to get family planning care and supplies. But, the OB/GYN doctor must still be in our Provider Directory so that TennCare will pay for the services. If you get family planning care and/or supplies from a doctor or clinic that is NOT in our Provider Directory, the doctor or clinic must call us at **800-468-9698** and let us know so we can pay for the family planning care and supplies.

Pregnancy

If you are already more than **three 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 **800-468-9698** 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 you plan to breastfeed or pump milk for your baby, you can see a lactation consultant for help during your pregnancy and after your pregnancy.

IMPORTANT: Tell TennCare Connect you are pregnant or have been pregnant in the last 12 months. Here is how you can tell us about a change:

- Call TennCare Connect at 855-259-0701
- Use your online account for TennCare Connect at **http://tenncareconnect.tn.gov**
- Go to a local Health Department and ask for assistance in telling TennCare about a pregnancy

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

After your baby is born

You and your baby both need follow-up care! Care for mom after childbirth is called postpartum care. Be sure you schedule follow up appointments with your doctor so your doctor can make sure you are OK after giving birth. You should see your doctor twice in the three months after you have your baby. The first visit is recommended within the first 3 weeks and the second visit should be between the fourth week and 12 weeks after childbirth. If you have complications or problems, your doctor may want to check on you more. Both your physical health and mental health are important. Talk to your doctor if you're feeling sad, crying a lot and you don't know why, or everything feels overwhelming and hopeless.

Some women may need to see their regular doctor (PCP), or a specialist, in the weeks and months after delivery to care for things like high blood sugar or high blood pressure.

Breastfeeding can be hard. You and your baby can see a lactation specialist for help. Call BlueCare if you need assistance in finding a lactation specialist near you.

Your baby needs a check-up with a doctor (PCP) a few weeks after birth. Care after your baby is born is called **postnatal care.** Postnatal care includes circumcisions done by a doctor and special screenings for newborns.

You **must** find a PCP for your baby and it's best 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 healthcare services.

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.

Children under age 2 can receive up to 100 diapers per month from certain pharmacies. A list of participating pharmacies is on the TennCare website.

IMPORTANT: Tell TennCare Connect 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 TennCare Connect about your baby as soon as you can. Call them at **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 TennCare Connect 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 one month old, if possible.

Preventive Care for Children (TennCare Kids – health care for your child and teen)

Check In, Check Up, and Check Back!

TennCare Kids is the name for TennCare's program to keep children healthy. 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 or substance use disorder 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 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 or substance use disorder) treatment that he or she needs.

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

- Born
- 3-5 days old

- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- 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's called TennCare Kids: TennCare's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). 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)

You also have a dental plan for your teeth called **Renaissance.** Their phone number is **866-864-2526.** You can call Renaissance 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 the time the first tooth comes in the mouth, or no later than the first birthday.

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

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

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 BlueCare 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 BlueCare 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: https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-13.20250801.pdf

Or, you can call us at **800-468-9698** 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 because of a diseased breast, 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 substance use disorder) 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 a 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, and toenails.
17. Sex reassignment 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 CHOICES and Employment 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 or Drug Efficacy Study Implementation– this means that research says they are not effective.
    - LTE or Less Than Effective– this means that research says they are less 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 (OTC) medicine (except medicine on the "covered adults" OTC list).
2. Allergy medicines you get from the pharmacy even if you have a prescription.
3. Medicine to treat acne and rosacea.
4. Eyeglasses, contact lenses 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.

5. Hearing aids or exams for your hearing for adults age 21 and older.

Part 3: TennCare Long-Term Services and Supports (LTSS) 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 **800-468-9698.** 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 get 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. 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 assess risk. 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 **800-468-9698.**

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 **866-836-6678.** Their local AAAD will help them find out if they qualify for TennCare and CHOICES.

Who can qualify to enroll in CHOICES?

There are (3) groups of people who can qualify for 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 (LTSS) 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 will 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 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 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.

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 that 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 Groups 2 and 3

Not everyone who qualifies to enroll in CHOICES Group 2 or Group 3 may be able to enroll. There is an enrollment target for CHOICES Group 2 and Group 3. 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 and Group 3 will be set by the state in TennCare Rules.

For CHOICES Group 2 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 you 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 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 or Group 3.

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 or Group 3, your name will be placed on a waiting list. Or, if you meet the guidelines for CHOICES Group 2, 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.

Receiving Services in the CHOICES Program

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. Everyone in CHOICES Group 2 has an individual cost neutrality cap which is usually related to the average cost of nursing home care. This amount is updated every year.

People in **CHOICES Group 3** receive **home care** (or HCBS) to prevent or delay the need for nursing home care. There is a cost limit for CHOICES Group 3 services. This limit is set by TennCare.

The **kinds** of home care covered in CHOICES Group 2 and Group 3 are listed below. 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**

  Personal Care allows visits up to 2,580 hours per calendar year.

  This means someone will help you with personal care needs and support in your home, on the job, or in the community. This can be things like helping with household chores such as fixing meals, cleaning, or laundry. Or they can run errands for you, like grocery shopping or picking up your medicine.

  This Personal Care service is only for you. Personal Care will do these services if no one else in the household can do them for you. This is not for other family members who are not enrolled in CHOICES.
- **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 daycare** (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.

- **Enabling technology –** (up to $5,000 per calendar year)– Enabling technology is the use of various forms of devices and technology to support independent living such as sensors, mobile applications, remote support systems and other smart devices. Enabling Technology can support a person in navigating their jobs and communities, gain more control of their environment, and provide remote support and reminders to assist a person in independent living.
- **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 jobs you might like and are 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 people in CHOICES Groups 2 and 3 over 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.

You can get Exploration 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.

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 or substance use disorder) 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 in your support plan **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**.

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

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 **bluecare.bcbst.com.** Or call us at **800-468-9698** 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 **800-468-9698** 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 BlueCare.

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. In CHOICES, the services available through Consumer Direction are:

- Personal care visits;
- 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:

1. 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.

2. Setting and managing your workers' schedule

- Set the schedule at which your workers will give your care.
- Make sure your workers clock in and out using an Electronic Visit Verification (EVV) system **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.

3. Supervising your workers

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

4. 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.

5. 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.

Representative for Consumer Direction

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.
- 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 a Fiscal Employer Agent (also called FEA). There are 2 kinds of help you will receive:

1. The FEA 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. The FEA 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.

Your Supports Broker will call you at least once a month. And they will visit you at least once every 6 months. These check-ins make sure that your health, safety and welfare are not at risk. They also monitor the quality of services being provided in Consumer Direction.

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 BlueCare 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 Personal Care, Community Transportation, 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 BlueCare, 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 anymore, 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 BlueCare instead.

Self-Direction of Health Care Tasks

You can direct and manage paid workers to complete health care tasks for you. This is called Self-Direction of Health Care Tasks, or SDHCT. A paid worker will do things like administer medicine for you. You or your authorized health care decision maker can choose the task. SDHCT is not the same as Consumer Direction or Self-Direction of HCBS.

SDHCT duties and functions are completed by a Consumer-Directed worker or a Direct Support Professional. This is covered service with CHOICES supports the member is authorized to receive, based on the decision, direction, and supervision of a CHOICES member receiving HCBS or the member's authorized health care decision maker.

Self-Direction of Health Care Tasks may be performed in a person's home or during employment or integrated community activities outside the home, as a component of HCBS.

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

Care Coordination and Role of the Care Coordinator

In CHOICES, we are responsible for managing your physical health, behavioral health (mental health or substance use disorder) 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.

Not sure who your Care Coordinator is or how to contact them? You can call us at 800-468-9698.

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 or substance use disorder) 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 BlueCare can do to help manage health problems or coordinate other kinds of physical and behavioral health (mental health or substance use disorder) 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.

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. These visits may occur more often if you get residential services or based on your needs.
- 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 $18,000 if you are in Group 3.

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 **800-468-9698.** 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 BlueCare, 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 **800-262-2873.**

Your Person-Centered Support Plan

In 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 get to help you meet your goals
- how often you will get those services and supports
- who will provide them, and
- the settings (or places) they will be provided.

Your Care Coordinator helps develop your support plan. They will help you to:

- Find 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 get, 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
- Make sure you get the services in your support plan.

Your support plan and how it's developed is very important. CHOICES can only pay for covered services that are part of an approved support plan.

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. BlueCare 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.

What if your needs change and you need more support?

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.

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.

Request a TennCare Review

MAIL: TennCare Division of Long Term Services and Supports
c/o CHOICES Review
310 Great Circle Rd.
Nashville, TN 37243

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

FAX: 615-532-9140

Keep the page that shows your fax went through.

Filing an Appeal

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 CHOICES 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 CHOICES 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.

Go to Part 6 of this handbook for more information on filing appeals.

CHOICES Consumer Advocate

In addition to your Care Coordinator, there is another person at BlueCare 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 BlueCare, like filing a complaint,

changing Care Coordinators or getting the care you need.
- Make referrals to the right BlueCare staff.
- Help fix problems with your care.

To reach the BlueCare CHOICES Consumer Advocate, call us at **800-468-9698.** 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 $19,764 per year. Minor home modifications, and any home health or nursing care you might need don't count against the $19,764 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 you 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.

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 and countable expenses. 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 BlueCare.

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

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, BlueCare 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.

Do you have medical bills for care you got before 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 eyeglasses and hearing aids 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, 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.

Where to send medical bills

Mail to:
TennCare Connect
P.O. Box 305240
Nashville, TN 37230-5240

Fax to:
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 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 BlueCare. 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 $18,000 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.

Estate Recovery

What is Estate Recovery?

Estate Recovery is the way TennCare collects money from the estates of people who received TennCare long-term services and supports and passed away. TennCare is required by federal law to recoup (get back) these payments after the

death of the member. This is referred to as "estate recovery." The kinds of care that must be paid back are listed below.

Your "estate" is the property, belongings, money, and other assets that you own at the time of your death. Estate recovery is using the value of your property after you die to pay TennCare back for care you got. Keep reading to find out who has to pay TennCare back and how much your estate will have to pay back.

TennCare can't ask for the money back until **after** your death. TennCare can't ask for more money back than what was paid for. TennCare can't ask your family to pay for your care out of their own pockets.

If the value of all of your assets at the time of your death is less than TennCare's bill, TennCare is only allowed to get the value of your assets and no more. For example, if the only thing that you own at the time of your death is a home valued at $50,000 but TennCare has a bill of $75,000, then TennCare is only allowed to collect $50,000. TennCare cannot ask your family to pay for the remaining amount.

Who has to pay TennCare back for their care?

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

- 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.

What kinds 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, known as home and community-based services or HCBS.
- Home Health or private duty nursing.
- Hospital care and prescription drugs related to your long-term care services.

How much will your estate have to pay TennCare back for your care?

To provide long-term care, TennCare contracts with a health insurance company (also called a "managed care organization" or "MCO"). When someone receives TennCare, TennCare pays a monthly premium to the insurance company. The

monthly premium is called a "capitation rate." In return, the insurance company pays the health care provider (like a nursing facility or other entity providing long-term care in the home/community) for the person's care. Under federal law, TennCare must ask to be paid back the premium payment it made to the insurance company for you.

The premium payment made to the insurance company is the same each month, no matter what services you actually receive that month. The premium payment can also be different depending on what type of long-term care you have and the part of the state you live in.

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

- You do not have money, property, or other assets when you die or
- The things you left can't be used to pay people you owe through probate court. An example is life insurance money.

What if I sell or give away my home while I am receiving TennCare?

Then you must tell TennCare that you sold or gave away your home, which can affect your TennCare eligibility. You must also tell TennCare about any transfer made five years before you received TennCare. If you do not tell them about the transfer, they can have the transfer set aside and ask to be paid back from your estate, family member(s), or any other person that participated in the transfer.

What are the reasons that TennCare can delay estate recovery?

In some situations, estate recovery is delayed or "deferred," which means that TennCare will not go after your estate until a later date. TennCare defers estate recovery for an individual's estate when:

- You have a surviving husband or wife. TennCare cannot collect money from your estate until the death of your husband or wife.
- You have a child that is under the age of 21. TennCare cannot collect money from your estate until your child is over the age of 21.
- You have a blind or permanently disabled child. TennCare cannot recover until the death of the disabled child.
- You have a son or daughter whose care kept you out of the nursing home for **at least** two years. TennCare cannot collect money from your estate until your son

or daughter no longer lives at the property.

- Your brother or sister whose care kept you out of the nursing home lived in your home for a year **before** you got nursing home or home care. If the brother or sister passes away or no longer resides at the property, then the deferral no longer exists.
- If the property is the family's only income, like a family farm.

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

To find out if the estate owes money to TennCare, your family or representative must submit a Request for Release Form to TennCare in one of three ways:

- Get the Request for Release online at: **https://www.tn.gov/content/dam/tn/tenncare/documents/releaseform.pdf**
- Get the Request for Release from the Probate Court Clerk's office by asking for a "Request for Release from Estate Recovery".
- **Get the Request for Release from TennCare by sending an email, letter, or fax to:**

Request for Release Form 1

Email: RFR.Tenncare@tn.gov.

Mail to:
Division of TennCare
Estate Recovery Unit
310 Great Circle Rd.
4th Floor
Nashville, TN 37243

Fax: 615-413-1941

What if you do have to pay TennCare money from your estate?

Your family or representative has many options if there is a TennCare claim:

1. They can pay the TennCare claim from your remaining belongings
2. Your estate can be admitted to "Probate." When this happens, a Court will appoint someone known as an administrator (or if you have a will this person is known as an executor) to sell your property, to pay any debts that you might have had while alive, and then give your heirs the remaining property/money if there is anything left. Your family or TennCare can request that an administrator be appointed for your estate.
3. They may apply for a deferral of Estate Recovery.

Do you have questions or need help with estate recovery?

Questions about estate recovery

EMAIL: Estate.recovery@tn.gov

MAIL: Division of TennCare
Estate Recovery Unit
310 Great Circle Road, 3W
Nashville, TN 37243

FAX: 615-413-1941

CALL: 844-629-0941

Renewals

As with all Medicaid programs, we are required to make sure that everyone still qualifies every year—called renewals. We must make sure you still meet the medical and financial rules for CHOICES. Be sure TennCare has your current address. If you move, tell us right away. Open your mail and watch for requests for information from TennCare so your coverage can continue. Your TennCare health plan can help if you ask them. If you lose CHOICES, there must be an open slot for you to enroll again.

Employment and Community First CHOICES

What is Employment and Community First CHOICES?

Employment and Community First CHOICES (ECF 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.

How do I apply for Employment and Community First CHOICES?

There is a limited amount of funding to serve people each year. This means that not everyone who wants to apply can enroll or get services right away.

There is a referral list for Employment and Community First CHOICES. To get on the referral list, you can complete a self-referral. Filling out the self–referral for Employment and Community First CHOICES does not mean you will be enrolled in the program. You must qualify to enroll in the program. There must be room in the

program to enroll you AND you must be in one of the groups that may qualify to get services now.

If you need help with a self-referral for Employment and Community First CHOICES, call us at **800-468-9698.**

ECF 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 ECF CHOICES. Instead, the home care you receive through ECF CHOICES will work together with the assistance you already receive to help you stay in your home and community longer. Care in ECF 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 Family Support program or Medicaid Alternative Pathways (MAPS), 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 other state or federal programs (like Meals on Wheels, homemaker, or the National Caregiver Family Support Programs) that you can now get through ECF CHOICES, you'll get the care you need through ECF CHOICES.

To see if you qualify to enroll in ECF CHOICES, call us at **800-468-9698.**

Does someone you know that isn't on TennCare want to apply for ECF CHOICES? They should contact the Department of Disability and Aging (DDA) Regional Intake office in their area of the state.

- West Tennessee (866) 372-5709
- Middle Tennessee (800) 654-4839
- East Tennessee (888) 531-9876

This office will help them find out if they qualify for TennCare and ECF CHOICES.

Who can qualify to enroll in Employment and Community First CHOICES?

There are 5 groups of people who can qualify to enroll in ECF CHOICES.

Essential Family Supports (This is sometimes called "Group 4.")

Family Support services are for families caring for a child under the age of 21 who has an intellectual or developmental disability (I/DD). The child must live at home with their family (not a foster family).

Adults age 21 with I/DD living at home with their family can also choose to enroll in this group if they qualify.

Essential Supports for Employment and Independent Living (This is sometimes called "Group 5.")

Essential Support services are for adults age 21 and older who have an I/DD but don't qualify for the level of care in a nursing home.

- A person age 18-21 with I/DD may be enrolled in this group if they can't live with their family anymore.
- A person who would qualify to receive care in a nursing home can choose to enroll in this group if ECF CHOICES Group 6 is full and their needs can be met with these services.

Comprehensive Supports for Employment and Community Living (This is sometimes called "Group 6.")

These services are only for adults age 21 and older who would qualify to get care in a nursing home. (This doesn't mean the person has to receive care in a nursing home. This program provides services at home and in the community. They just need to qualify for nursing home care.)

- A person age 18-21 with I/DD may be enrolled in this group if they can't live with their family anymore.
- Comprehensive Support services are for people who need more services to help them live in the community and achieve their employment and community living goals.

Intensive Behavioral Family Supports (This is sometimes called "Group 7.")

This group is for a small number of children under age 21 who live with their family and have I/DD and severe behavior support needs that place the child or others at

risk of serious harm. The behaviors are so challenging that the child is at risk of being placed outside the home. This group provides mental health treatment and other services in the home with the family. (The family must be willing to be part of the child's treatment.) The services will train and support the family to support the child so they can keep living safely together. People are usually in this group short-term. Once the person is stable in the community, they will move to a different benefit group that can safely meet their needs.

Comprehensive Behavioral Supports for Employment and Community Living (This is sometimes called "Group 8.")

This group is for a small number of adults who have I/DD and severe behavior support needs and are moving into the community from a place with lots of structure and supervision. This could be coming from a mental health hospital, the foster care system, jail, or a nursing home. These services are mostly for adults age 21 or older. But sometimes, a person age 18-20 can get them too. They combine 24/7 residential services with mental health treatment and support. People are usually in this group short-term. Once the person is stable in the community, they will move to a different benefit group that can safely meet their needs.

TennCare Long-Term Services and Supports will decide if you meet the level of care rules to enroll in ECF CHOICES. TennCare Member Services will decide if you meet the income and resource rules to qualify for Medicaid long-term services and supports through ECF CHOICES. We'll help you fill out the papers they need to decide. If TennCare says yes, to enroll in ECF CHOICES 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 expenditure cap for your ECF CHOICES Group. 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 the expenditure cap for your ECF CHOICES Group, you can't be in ECF CHOICES. 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.

Limits on Enrollment into Employment and Community First CHOICES

Not everyone who qualifies to enroll in ECF CHOICES may be able to enroll. There is an enrollment target for ECF CHOICES Groups. 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 care. It also helps to ensure that there are enough home care providers to deliver needed services.

Some slots will be held back (or reserved) for emergencies. This includes things like when a person has a primary caregiver who is at least 75 years old or the primary caregiver is permanently incapacitated or deceased. 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 ECF CHOICES.

If you don't meet the guidelines for reserved slots or there are no slots available and you qualify to enroll in ECF CHOICES, your name will be placed on a referral list.

When there are slots available, TennCare can enroll from the referral list based on priority. These priority rules are in TennCare Rules.

Receiving Services in the ECF CHOICES Program

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

Essential Family Supports

Or "Family Support services" for short.

(This is sometimes called "**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 exceed the cost cap each year. The cost cap is set by TennCare every year. 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.

Essential Supports for Employment and Independent Living

Or "Essential Support services" for short.

(This is sometimes called "**Group 5**.")

These services are **only** for adults age 21 and older.[2] 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 exceed the cost cap each year. The cost cap is set by TennCare every year. It starts on January 1st each year and ends on December 31st 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.

You may also be able to go over your cap to get employment services OR if you need more help for a short time to transition safely to living in the community.

Comprehensive Supports for Employment and Community Living

Or "Comprehensive Support services" for short.

(This is sometimes called "**Group 6**.")

These services are **only** for adults age 21 and older who would qualify to get care in a nursing home.[3] (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" tells us how much support you need. Everyone in the Comprehensive Support Services group

(ECF CHOICES Group 6) will have an assessed "level of need." The assessment is not done by TennCare or your health plan.

The total cost of Comprehensive Support services you get can't be more than your cost cap each year. It starts on January 1st each year and ends on December 31st each year. What if you have an emergency and need more services to stay in the community? ONLY if you have a low, moderate, or high level of need, you may be able to get more Comprehensive Support services for that year. But they can't cost more than $7,500.

ONLY if you have a low, moderate, or high level of need, you may also be able to go over your cap to get employment services. Except for these, no one can get Comprehensive Support services that cost more than their cost cap 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.

  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.

Intensive Behavioral Family Supports
(This is sometimes called "**Group 7**.")

This group is for a small number of children under age 21 who live with their family and have I/DD and severe behavior support needs that place the child or others at risk of serious harm. The behaviors are so challenging that the child is at risk of being placed outside the home. This group provides mental health treatment and other services in the home with the family. (The family must be willing to be part of the child's treatment.) The services will train and support the family to support the child so they can keep living safely together.

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). These average yearly costs change every year.

This **doesn't** mean you will get services in an ICF/IID. 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).

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

Comprehensive Behavioral Supports for Employment and Community Living
(This is sometimes called "**Group 8.**")

This group is for a small number of adults who have I/DD and severe behavior support needs and are moving into the community from a place with lots of structure and supervision. This could be coming from a mental health hospital, the foster care system, jail, or a nursing home. These services are *mostly* for adults age 21 or older. But sometimes, a person age 18-20 can get them too. They combine 24/7 residential services with mental health treatment and support. People are usually in this group short-term. Once the person is stable in the community, they'll move to a different benefit group that can safely meet their needs.

- For the first year, your cost cap is based on the average yearly cost of services in a public ICF/IID (Intermediate Care Facility for Individuals with Intellectual Disabilities).
- For the second year and every year after, your cost cap is based on the average yearly cost of services in a private ICF/IID.

These average yearly costs change every year.

This **doesn't** mean you will get services in an ICF/IID. 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.

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 of 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 agree to complete the Employment Informed Choice process **before** you can get certain kinds of Independent Community Living Supports. Then, you can get other kinds of services **at the same time.** 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.

Enabling technology

Enabling technology is a new service (up to $5,000 per calendar year in combination with Assistive Technology)– Enabling technology is the use of various forms of devices and technology to support independent living such as sensors, mobile applications, remote support systems and other smart devices. Enabling Technology can support a person in navigating their jobs and communities, gain more control of their environment, and provide remote support and reminders to assist a person in independent living.

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 or substance use disorder) 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 **support services** must be approved in your support plan **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**.

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

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 **bluecare.bcbst.com.** Or call us at **800-468-9698** 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 **800-468-9698** 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 BlueCare.

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 Employment and Community First CHOICES, the services you can Consumer Direct are:

- Personal Assistance
- Supportive Home Care
- Respite
- Community Transportation

In Consumer Direction, you employ the people who give some of your support 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 clock in and out using an EVV system **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.

Representative for Consumer Direction

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.

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 a Fiscal Employer Agent (also called FEA). There are 2 kinds of help you will receive:

- The FEA 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.
- The FEA 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.

Your Supports Broker will call you at least once a month. And they will visit you once every 6 months. These check-ins help to make sure that your health, safety and welfare are not at risk. They also monitor the quality of services being provided in Consumer Direction.

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 services you'll get depends on what you need to support you and help you reach your goals. 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 BlueCare for care that you can't get through Consumer Direction.

Can you pay a family member or friend to provide support 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 Personal Assistance, Supportive Home Care, Community Transportation, or Respite.

And, Employment and Community First CHOICES can't pay family members or others to provide care they would have given for free. Employment and Community First 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 Employment and Community First CHOICES and need services that can be consumer directed your Support Coordinator will talk with you about Consumer Direction. If you want to be in Consumer Direction, your Support 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 BlueCare, 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 anymore, you will **not** stop getting long-term services and supports. You will still be in Employment and Community First CHOICES. You'll get the services you need from a provider who works with BlueCare instead.

Self-Direction of Health Care Tasks

You can direct and manage paid workers to complete health care tasks for you. This is called Self-Direction of Health Care Tasks, or SDHCT. A paid worker will do things like administer medicine for you. You or your authorized health care decision

maker can choose the task. SDHCT is not the same as Consumer Direction or Self-Direction of HCBS.

SDHCT duties and functions are completed by a Consumer-Directed worker or a Direct Support Professional. This is covered service with ECF CHOICES supports the member is authorized to receive, based on the decision, direction, and supervision of an ECF CHOICES member receiving HCBS or the member's authorized health care decision maker.

Self-Direction of Health Care Tasks may be performed in a person's home or during employment or integrated community activities outside the home, as a component of HCBS.

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

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.

Your Support Coordinator will play a very important role. Your Support Coordinator is your primary contact person and is the first person that you should go to if you have any questions about your services.

Not sure who your Support Coordinator is or how to contact them? You can call us at 800-468-9698.

Your Support Coordinator will:

- Provide information about Employment and Community First 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 or substance use disorder) 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 5, 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.
- Do a comprehensive, individual assessment of your health and long-term services and supports needs; and
- Develop a Person-Centered Support Plan.

Changing Support Coordinators

If you're unhappy with your Support Coordinator and would like a different one, you can ask us. You can have a new Support Coordinator if one is available. That doesn't mean you can pick whoever you want to be your Support Coordinator. We must be able to meet the needs of all Employment and Community First CHOICES members and assign staff in a way that allows us to do that. To ask for a different Support Coordinator, call us at **800-468-9698.** 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 help to address any problems or concerns you have with your Support Coordinator.

There may be times when BlueCare will have to change your Support Coordinator. This may happen if your Support Coordinator is no longer with BlueCare, is off work for a while, or has too many members to give them the attention they need. If this happens, BlueCare 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. If you need help after regular business hours that won't wait until the next day, you can call us at **800-262-2873.**

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 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. They 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 and how it's developed is very important. Employment and Community First CHOICES can only pay for covered services that are part of an approved support plan.

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. BlueCare 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 what if your needs change and you need more support?** Tell your Support Coordinator. Your Support Coordinator will help you 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 **BlueCare** 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 submit a written request.

Requesting a TennCare Review 1

MAIL: TennCare Division of Long Term Services and Supports
c/o ECF CHOICES Review
310 Great Circle Rd.
Nashville, TN 37243

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

FAX: 615-532-9140

Keep the page that shows your fax went through.

Filing an Appeal

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.

Go to Part 6 of this guide for more information on filing appeals

Member Advocate for Employment and Community First CHOICES

In addition to your Support Coordinator, there is another person at BlueCare 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 BlueCare staff.

To reach the BlueCare Member Advocate for Employment and Community First CHOICES, call BlueCare at **800-468-9698.** Ask to speak with the Member Advocate for Employment and Community First CHOICES.

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 Qualifying Income Trust (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.

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

What if you DON'T pay the patient liability you owe?

Four 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, BlueCare 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 BEFORE 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 AFTER TennCare started that TennCare doesn't cover? This includes eyeglasses, 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.

Where to send medical bills

Mail to:
TennCare Connect
P.O. Box 305240
Nashville, TN 37230-5240

Fax to:
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.

Disenrollment from Employment Community First CHOICES

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

- You no longer qualify for Medicaid.

- You no longer need the level of care provided through Employment and Community First CHOICES.
- You refuse to allow a Support Coordinator into your home. If a Support 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.
- You no longer need and aren't receiving any long-term services and supports.
- You do not pay your patient liability.

You can also be disenrolled if:

The cost of care you need in the home or community will be more than the cost of your expenditure cap. Except for ECF CHOICES Group 4, the cost of care includes any home health or private duty nursing you may need.

Your Support 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 your expenditure cap.

If the **only** way you qualify for Medicaid is because you receive long-term services and supports and you're disenrolled from Employment and Community First 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.

Renewals

As with all Medicaid programs, we are required to make sure that everyone still qualifies every year—called renewals. We must make sure you still meet the medical and financial rules for Employment and Community First CHOICES. Be sure TennCare has your current address. If you move, tell us right away. Open your mail and watch for requests for information from TennCare so your coverage can continue. Your TennCare health plan can help, if you ask them. If you lose

Employment and Community First CHOICES, there must be an open slot for you to enroll again.

Katie Beckett

What is the Katie Beckett Program?

The TennCare Katie Beckett Program is for children under age 18 with disabilities or complex medical needs who are not Medicaid eligible because of their parent's income or assets. It helps to provide care for the child's medical needs or disability that private insurance does not cover. The care is provided in the child's home or in the community.

How do I apply for the Katie Beckett Program?

If your child is eligible for TennCare, your child is not eligible for the Katie Beckett Program. There is a limited amount of funding to serve people each year. This means that not everyone who wants to apply can enroll or get services right away.

Does someone you know that isn't on TennCare want to apply for the Katie Beckett Program? They should contact the Department of Disability and Aging (DDA) Regional Intake office in their area of the state.

- West Tennessee (866) 372-5709
- Middle Tennessee (800) 654-4839
- East Tennessee (888) 531-9876

This office will help them find out if they qualify for the Katie Beckett Program.

Who can qualify to enroll in the Katie Beckett Program?

There are 3 groups in the Katie Beckett Program.

1. **Katie Beckett Part A** (or "**Part A**" for short) is for children who would qualify for care in a medical institution—like a hospital, nursing home or ICF/IID (Intermediate Care Facility for Individuals with Intellectual Disabilities). But they want care at home instead.
2. **Medicaid Diversion, also known as Katie Beckett Part B** (or "**Part B**" for short) is for children who don't qualify for care in an institution. But they're "at risk" of going into one unless they can get services.
3. **Continued Eligibility** (or "**Part C**" for short) is for children who have Medicaid now, but their Medicaid is ending because their parents' income or resources increased. Part C may allow the child to keep Medicaid if they would qualify to enroll in Part A, but there isn't a slot open for the child right now. (We tell you more about "slots" below.)

If a child enrolls in Part C and then gets a Part A slot, they must move to Part A. They can't stay in Part C anymore.

Limits on Enrollment into the Katie Beckett Program

There is a limit on how many children can enroll in Part A and Part B. The limits are based on the amount of funding approved for the program.

Part A has funding to serve **up to** 300 children. The actual number of children served in Part A will depend on the cost of services each child needs. If the cost of services is lower than expected, we can serve more children. If the cost of services is higher, we will serve fewer children.

Part B has funding to serve **up to** 4,700 children.

We sometimes call these limits for each Part "slots." To enroll your child in Part A or Part B, there must be an open slot in that Part *for your child*.

How does TennCare decide who gets a slot?

Part A slots are filled based on **need.** Children with the most complex medical needs will be served first. Children with the most complex behavioral needs will be served next. Other children who meet institutional level of care will be served after that.

What if there is a tie—2 children have the same medical or behavioral needs and there is only 1 slot? TennCare will decide who gets the slot based on things like:

- If the child's condition is getting worse;
- The kinds of medical care the child has received;
- The kinds of medical and other care the child needs daily; and
- Other things that impact family caregivers.

Children with the highest needs will be served first in Part A.

Part B slots are filled on a **first come, first serve** basis. Children will be enrolled into open Part B slots based on when they applied or were placed on the Part B waiting list.

Receiving Services in the Katie Beckett Program

The services your child can receive in the Katie Beckett Program depend on which Part they are enrolled in.

Services for Part A

Children in Part A qualify for all the Medicaid benefits for children. This includes things like:

- Doctor and hospital visits;
- Dental care;
- Home health care;
- In-home nursing services;
- Medical equipment and supplies;
- Occupational Therapy, Physical Therapy, and Speech Therapy; and
- Non-emergency transportation (NEMT).

The services must be medically necessary. Private insurance must pay *first*. TennCare will help pay for those things private insurance doesn't cover, including insurance deductibles and co-pays. Providers are expected to accept Medicaid as payment in full for Medicaid benefits. They should not bill you after TennCare has paid, even if TennCare doesn't pay the full amount.

Children in Part A can also get extra help for their disability. This includes services that help the family meet their child's needs at home. These are called **H**ome and **C**ommunity **B**ased **S**ervices or **HCBS.** The total cost of HCBS a child in Part A gets can't be more than $15,000 each year. This is the child's yearly limit. It starts on January 1st each year and ends on December 31st each year.

Children in Part A receive care up to the Comparable Cost of Institutional Care.

In Katie Beckett Part A and C, TennCare will help pay for care for your child at home. The amount TennCare pays for the child's care at home can't be more than it would cost to provide their care in an institution. This is called "Comparable Cost of Institutional Care." If it would cost more to provide your child's care at home, your child doesn't qualify for Part A or Part C. This is part of federal and state law and TennCare's Katie Beckett waiver.

Your child's cost of care includes ALL of the care TennCare pays for like doctor visits, hospital stays, and prescription drugs. Your child would get some kinds of care in an institution or at home. So, for the cost of care at home, we count things a child wouldn't get in an institution. These are things like: home health, private duty nursing, personal medical equipment, outpatient or in-home therapy, community-based mental health services (including residential treatment), and other Home and Community Based Services (HCBS).

Your child's cost of care in an institution depends on the kind of care your child might need and qualify to receive—like a hospital or nursing home. TennCare uses medical records to decide the kind of institutional care your child would qualify to receive. To be in Katie Beckett Part A or Part C, your child's care at home can't cost more than care in an institution.

In Katie Beckett, you must sign a form stating you understand that your child's total costs can't be more than their Comparable Cost of Institutional Care.

Services in Part B

Children in Part B won't get Medicaid benefits. But, the child will get services (HCBS) to help the family meet the child's needs at home. This includes help paying for the child's insurance and care the child needs that insurance doesn't cover. The total cost of HCBS a child in Part B gets can't be more than $10,000 each year. This is the child's yearly limit. It starts on January 1st each year and ends on December 31st each year.

Services in Part C

Children in Part C will receive all the Medicaid benefits for children. Children in Part C will **not** receive HCBS.

The kinds of services covered in each Part of the Katie Beckett Program are listed in a chart at the end of these pages. Some of the services have limits. This means that TennCare will only pay for a certain amount of these services. For HCBS, the chart tells you how each service can help your child, what Parts cover it, and the limits on that service. If you have questions about a service, ask your TennCare health plan or DDA.

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 or substance use disorder) services before you receive them even if a doctor says you need the services. This is called prior authorization. Services that must have 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 in your support plan **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**.

Using Katie Beckett HCBS providers that work with your TennCare health plan or DDA

You must use providers that work with your TennCare health plan (or in Part B, with DDA) for HCBS. In Part A, your health plan will tell you how to find a list of those providers—called a Provider Directory. The online Provider Directory is updated every week. You can also call your TennCare health plan to find out if a provider is in their network. In Part B, your Katie Beckett Case Manager will share a list of providers to pick from.

What is Consumer Direction?

Consumer Direction is a way of getting **some** of the services your child needs in the Katie Beckett Program. Consumer Direction gives you more choice and control over **who** gives your child's support and **how** your child's support is given. In Katie Beckett Part A and Part B, the services you can direct include only:

- Respite
- Supportive Home Care
- Community Transportation

In Consumer Direction, you actually employ the people who give some of your child's services —they work **for you** (instead of a provider). This means that 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 clock in and out using an EVV system **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 (to make sure your child's needs are met).
- Activate the back-up plan when needed.

You also have to manage the care your child needs within your child's approved budget for each service.

What if you can't do some or all of these things? Then you can choose another family member, friend, or someone close to you to do these things for your child. You'll learn more about that if you choose Consumer Direction.

Can you pay a family member or friend to provide care 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 care to meet needs that **can't** be met by family members or others who help your child. And, you **can't** pay yourself or anyone who lives in the home with your child to provide Respite or Supportive Home Care.

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 your child. 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 your child. 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 Case Manager if you have any questions about self-direction of health care tasks.

Your Nurse Care Manager

In Katie Beckett Part A, you will have a Nurse Care Manager. You should know who your Nurse Care Manager 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.

Your Nurse Care Manager will play a very important role. Your Nurse Care Manager is your primary contact person and is the first person that you should go to if you have any questions about your services.

Not sure who your Nurse Care Manager is or how to contact them? You can call us at 800-468-9698.

Your Nurse Care Manager will:

- Provide information about the Katie Beckett Program 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 or substance use disorder) and long-term services and supports needs.
- Help to fix problems and answer questions that you have about your care.
- Communicate with your providers to make sure they know what's happening with your health care and to coordinate your service delivery.
- Do a comprehensive, individual assessment of your health and long-term services and supports needs; and
- Develop a Person-Centered Support Plan.

Changing Nurse Care Managers

If you're unhappy with your Nurse Care Manager and would like a different one, you can ask us. You can have a new Nurse Care Manager if one is available. That doesn't mean you can pick whoever you want to be your Nurse Care Manager. We must be able to meet the needs of all Katie Beckett members and assign staff in a way that allows us to do that. To ask for a different Nurse Care Manager, call us at **800-468-9698.** Tell us why you want to change Nurse Care Manager. If we can't give you a new Nurse Care Manager, we'll tell you why. And, we'll help to address any problems or concerns you have with your Nurse Care Manager.

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

You can contact your Nurse Care Manager 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 Nurse Care Manager anytime you have a change in your health condition or other things that may affect the kind or amount of support you need. If you need help after regular business hours that won't wait until the next day, you can call us at **800-262-2873.**

Your Person-Centered Support Plan

In Katie Beckett Part A and Part B, each child must have a support plan. (In Part A, it's called a **P**erson-**C**entered **S**upport **P**lan or **PCSP.** In Part B, it's called an **I**ndividual **S**upport **P**lan or **ISP**.**)** This is the plan that helps guide the services and supports the child will receive. It 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 Nurse Care Manager or Katie Beckett Case Manager helps develop your support plan. They 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 and how it's developed is very important. Katie Beckett Part A and Part B can only pay for covered HCBS that are part of an approved support plan.

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

- You get to help 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 Nurse Care Manager or DDA Katie Beckett Case Manager 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. Your health plan or DDA will try to give you the providers you want. (The provider must be contracted with your health plan or DDA 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.

What if your child's needs change and your child needs more support?

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

Filing an appeal

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 child's needs and you think they should get more and/or different services.
- You can appeal if you don't agree with the services in your child's support plan.
- You can appeal if a covered service that your child needs isn't in your support plan.
- You can appeal if your request to have your child's support plan changed is denied, or your child's support plan is not changed enough to meet your needs.
- And, you can appeal if a service is in your child's 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 your child needs it, your child will get the service.

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

TennCare can only pay for services that are covered in the benefit group your child is 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 your child has 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, your child 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.

Go to Part 6 of this handbook for more information on filing appeals.

Other Requirements for the Katie Beckett Program

Getting and keeping private insurance

To enroll in Part A, a child must have and keep private insurance. This is the insurance their parents get from their job or buy separately. If a child doesn't have private insurance when they apply, TennCare will allow the child to enroll and wait for the next open enrollment period to buy insurance.

What if the child doesn't have private insurance and doesn't get it by January 15th of the following year? They won't qualify for Part A anymore. What if a child has private insurance but loses it after they enroll? You must tell TennCare right away. They will have 60 days after it ends to get private insurance again.

The new private insurance must meet the federal rules for minimum essential coverage. If your child doesn't have private health insurance by the due date, your child won't qualify to keep Katie Beckett anymore.

What if you can't afford private insurance?

If a child applying for Katie Beckett doesn't have private insurance, the family can ask for a **hardship exception.** A hardship exception can only be approved **IF** one of these things is true:

- The cost of private insurance for the child is more than 5% of their parents' income.
- The parents' employer doesn't offer insurance and the family's income is less than 400% of federal poverty level. (This is because the family won't qualify for premium assistance to help buy insurance on the federal marketplace.)

A hardship exception is ONLY available when a child first applies for Katie Beckett AND doesn't already have private insurance. You can't ask for hardship if your child already has private insurance OR if you lose private insurance later.

If TennCare decides the child qualifies for hardship, the family will still have to buy private insurance for the child. But TennCare will help pay for the child's part of that insurance. You must provide proof of the cost of the child's private insurance to get this help.

How will the child's portion of private insurance be calculated?

The child's cost of private insurance will be calculated by dividing the total premium by the number of family members covered by the policy. This likely overstates the child's portion of cost, since insurance usually costs more for adults. This is a simple method that favors the interest of families.

Katie Beckett Part A Premiums

To qualify for Part A, the child's parents must pay a monthly premium if their income is more than 150% of the federal poverty level. The amount of the premium will depend on the family's income, the number of people in the family, and the cost of the child's private insurance. The amount a parent pays for the child's part of private insurance will be deducted from the Part A premium amount. You can find examples of how this works on the TennCare and DDA Katie Beckett websites. Premium amounts may be adjusted each year to account for changes in the Federal Poverty Level (FPL).

The first month of premium must be paid *before* a child can be enrolled in Part A. If the first month's premium is not paid within 60 days, the slot will be given to another child. Your child will have to reapply for Katie Beckett.

Families will pay premiums monthly through automatic bank draft. You must pay your premium every month. If a family doesn't pay the Part A premium each month, a child will be disenrolled from the program.

- If the premium payment is more than 30 days late, a child will stop getting services until it is paid.
- If the premium payment is more than 60 days late, a child will be disenrolled from Part A.

A notice will be sent before either of these things happen. The family can appeal if they think there's a mistake.

If your child is disenrolled from Part A for not paying premiums, you will have to reapply for Katie Beckett. You will have to pay the premiums you owe before the child could qualify again. And, there must be an open slot. The child's slot will not be held.

Disenrollment from the Katie Beckett Program

Your child's enrollment in the Katie Beckett Program and receipt of long-term services and supports can end for several reasons. We can recommend a member's disenrollment from the Katie Beckett Program, but TennCare will make the final decision. Some of the reasons you could be disenrolled from the Katie Beckett Program include:

- You fail to pay premiums timely.
- Your child no longer needs the level of care provided through the Katie Beckett Program.
- Your child is admitted to a medical institution for a period of at least 30 days unless the child is reasonably expected to discharge soon.
- Your child is determined Medicaid eligible in another category.

If your child is disenrolled from the Katie Beckett Program, their TennCare will 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.

Renewing Katie Beckett coverage each year

As with all Medicaid programs, we are required to make sure that every child still qualifies every year—called renewals. We must make sure you still meet the medical and financial rules for Katie Beckett. Be sure TennCare has your current address. If you move, tell us right away. Open your mail and watch for requests for information from TennCare or DDA so your child's coverage can continue. In Part A and Part C, your TennCare health plan can help, if you ask them. If a child loses Katie Beckett, there must be an open slot for them to enroll again. DDA will renew Katie Beckett each year for children in Part B.

What is Abuse, Neglect and Exploitation?

TennCare members 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 result 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 or someone you know is a victim of abuse, neglect or exploitation or that any other member is a victim of abuse, neglect or exploitation, please tell your Care Coordinator, Support Coordinator or Case Manager.

Care Coordinators, Support Coordinators, Case Managers, and providers must report any suspected case of abuse, neglect or exploitation to DDA.

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

The DDA Abuse Hotline for reporting allegations is: **1-888-633-1313**

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

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 BlueCare. 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 **877-236-0013.**

Community Living Supports (CLS) Ombudsman

CLS is a type of support you can receive in your home if you are enrolled in CHOICES or the Employment and Community First (ECF) CHOICES programs.

This Ombudsman works for the Area Agency on Aging and Disability in your area. BlueCare 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.

You can also call 1-866-836-6678 for free from anywhere in the state to be directed to your nearest Area Agency on Aging and Disabilities (AAAD).

Beneficiary Support System

TennCare contracts with Disability Rights TN (DRT) to help people applying for or enrolled in CHOICES, Employment and Community First CHOICES, or Katie Beckett. We call this a beneficiary support system (BSS).

Here are things DRT can help you with:

- Connect you to help so you can apply for CHOICES, Employment and Community First CHOICES, or Katie Beckett
- Explain your rights and responsibilities
- Answer questions about TennCare, including CHOICES, Employment and Community First CHOICES, or Katie Beckett
- File and resolve concerns or complaints
- File appeals or find out about an appeal you've filed
- Provide facts about state fair hearings

There is no cost for any service. DRT can work with TennCare and your health plan to get answers if you need more help.

Here are ways you can ask DRT for help:

Ways to ask DRT for help

	Fill out form online. Go to the DRT Website at https://www.ltsshelptn.org/
	Call DRT for free at **888-723-8193.**
	Email DRT at this address: benefitshelp@disabilityrightstn.org Make sure to put this in your email: • Your name or name of person needing help • Call back number • Best call back time

DRT has interpreter services, translation services, and other aids available at no cost to you. Tell DRT if you need this kind of help.

After you ask DRT for help, a Support Specialist will review your request. Here's what can happen next:

- You may get information and resources to help you.
- You may be referred to DRT's intake team for more help.
- You may be referred to TennCare, your TennCare health plan, or someone else for next steps. DRT can help with these next steps.

Part 4: How the TennCare Program Works for You

What you pay for your healthcare – Copays

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 BlueCare 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.

Important: None of the doctors or health care providers in BlueCare can refuse to give you medically necessary services because you don't pay your co-pays.

But, BlueCare 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 BlueCare 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 BlueCare card or call TennCare Connect at **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 134% federal poverty level*	none	none	none	none	none
TennCare Standard **children** under age 21, from 134% to 199% federal poverty level*	$3 co-pay for Brand names; $1.50 co-pay for generics	$5	$5	$8.20	$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 and could get care in an institution if they wanted it (CHOICES 1, CHOICES 2, some people in ECF CHOICES 4, ECF CHOICES 6, ECF CHOICES 7, ECF CHOICES 8)	none	none	none	none	none

Member	Prescription co-pay	PCP (general doctor) co-pay	Specialist co-pay	Emergency Room Use (if not admitted)	Hospital Stay co-pay
TennCare **adults** 21 and older, who get long-term care that TennCare pays for and who do not qualify for care in an institution (CHOICES 3, some people in ECF CHOICES 4, ECF CHOICES 5)	$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 TennCare's Eligibility Reference Guide: **https://www.tn.gov/content/dam/tn/tenncare/documents/eligibilityrefguide.pdf**

Do you have TennCare Medicaid? You can go to page 152.

The next section 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 healthcare, look at your BlueCare card or call TennCare Connect at **855-259-0701.**

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 Member Medical Appeals for free at **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 TennCare Member Medical Appeals **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 TennCare Connect as soon as possible.

Do you have questions about co-pays or your quarterly limit? TennCare Connect can answer those questions too. Call them for free at **855-259-0701.**

How TennCare works with other insurance and Medicare

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

Part 1 of this handbook goes over 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. This section will go over 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.

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.
- TennCare Connect 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 **800-468-9698** for help.

TennCare covers air ambulance transportation services. There is no out of pocket cost to members for these services. Air ambulance companies are not the same as insurance coverage, members cannot enroll in a membership plan with an air ambulance company.

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.

Important: 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 **800-468-9698.**

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.

Important: Medicare charges you for premiums, deductibles, and co-pays. If you can't pay for these, you can apply for a program called **Qualified Medicare Beneficiary or QMB.**

QMB pays for:

- Your Medicare premiums.
- The hospital deductible that Medicare doesn't pay.
- The part of each doctor bill that Medicare doesn't pay.

Apply for QMB by calling TennCare Connect at 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 **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 **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 a BlueCare 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 **800-468-9698** 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 BlueCare card, call **800-468-9698.**
- For a new Prescription Card, call TennCare's pharmacy help desk at 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 **800-468-9698.** 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 **800-468-9698.** 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 healthcare 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 **800-468-9698** 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 **800-468-9698.** 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:

- Does the doctor take the health plan you want to change to?
- Is the doctor 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 **90** 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 90 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 **only** during the month of **March.** Your new health plan assignment would begin May 1st. 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 **only** during the month of **May.** Your new health plan assignment would begin July 1st. 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 1st. 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.

Do you get LTSS (Long-Term Services and Supports*)?* You can also ask to change health plans if care you need is not available in your current plan but is available in

a different health plan. The hardship rules below also apply to LTSS CHOICES and Employment and Community First CHOICES.

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.

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 TennCare Member Medical Appeals at **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 TennCare Member Medical Appeals, 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.

** 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.

Mail your request to:
TennCare Member Medical Appeals
P.O. Box 000593
Nashville, TN 37202-0593

Fax to:
888-345-5575

Need help getting your prescription medicines?
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 **800-468-9698.**

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 **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 2 brand name medicines this month?

- Call your doctor to see if you need **all** the medicine you're taking.
- **What if he or she 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 Automatic **Exemption Lists**. (That's TennCare's lists of medicines that won't count against your prescription limit.)
- Even if you've gotten **2** brand name medicines in 1 month, you **can** still get medicines on those lists.
- If you asked TennCare to pay for too many **brand name medicines**, ask your doctor to **prescribe generic medicines.**

For more information on the Automatic Exemption Lists, see Part 2 and Part 5 of this handbook. To get a current list of both, go to:

https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/AutoExempt-Attestation-Drug-List.pdf

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 **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 CoverRX at **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 **TennCare Connect** at **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 services that TennCare pays for.

For problems about physical and/or behavioral health (mental health, alcohol or substance use disorder) care, always call us at **800-468-9698** first.

If you still can't get the care you need, you can call **TennCare Member Medical Appeals** at **800-878-3192.** Call Monday through Friday from 8:00 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 or substance use disorder) 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 **800-468-9698.** 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 your TennCare could end

1. You can ask to end your TennCare by mail or by phone.

MAIL: Send a letter to TennCare Connect that says you want to end your TennCare.

Include your name, social security number and make sure you **sign** the letter.

TennCare Connect
P.O. Box 305240
Nashville, TN 37230-5240

CALL: Call TennCare Connect for free at **855-259-0701.**
Let them know you want to end your TennCare.

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.

Mail to:
TennCare Connect
P.O. Box 305240
Nashville, TN 37230-5240

Fax to:
855-315-0669

2. 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 BlueCare or TennCare, more than once.
- If you don't fill out your Renewal Packet 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 a Renewal Packet 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 we've made a mistake.

TennCare Advocacy Program

Important: 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 800-758-1638.

Part 6: TennCare Appeals

TennCare Appeals

An appeal is one way to make sure TennCare makes decisions using correct information. 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.

You can appeal if you disagree with a medical coverage decision by TennCare or BlueCare. This is called a Medical Service Appeal.

You can also appeal if you cannot get or keep TennCare. This is called an eligibility appeal.

Medical Service Appeals

Medical Service appeals are for people who have TennCare. Medical Service appeals are for problems like getting your health plan to OK a service your doctor says you need or getting assigned to the health plan you want. Medical Service appeals go to TennCare Member Medical Appeals. Page 170 tells you more about filing a medical service appeal.

BlueCare will send you a letter if your doctor's request for you to get a medicine or medical service is denied. BlueCare will also send a letter if we try to stop or reduce care you have been getting. The letter will tell you how you can appeal.

Whenever you need a service that BlueCare has denied, you have the right to ask TennCare for an appeal. For problems getting health care, always call us at **800-468-9698** first.

If you **still** can't get the care you need, you can file a medical appeal by calling **TennCare Member Medical Appeals** at **800-878-3192.**

You have 60 days after you find out there's a problem to appeal. So, if you get a denial letter from BlueCare, you have 60 days from the date on the denial letter to file an appeal.

- For care or medicine you still need, you have **60 days** after TennCare or

BlueCare 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 expedited 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 Member Medical Appeals (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 **888-345-5575.**

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 decision within 90 days from the date you filed your appeal.

How to File a Medical Appeal

File a medical appeal

CALL: You can call TennCare Member Medical Appeals for free at 800-878-3192. We're here to help you Monday through Friday from 8:00 a.m. until 4:30 p.m. Central Time.

MAIL: You can mail an appeal page **or** a letter about your problem to:

TennCare Medical Member Appeals
P.O. Box 000593
Nashville, TN 37202-0593

To print an appeal page off the Internet, go to: **https://www.tn.gov/content/dam/tn/tenncare/documents/medappeal.pdf.**

If you give your OK, someone else like a friend or your doctor can fill the page out.

	If you need another medical appeal page or want TennCare to send you one, call **TennCare Member Medical Appeals** at **800-878-3192.** Or, you can write your appeal on plain paper. Keep a copy of your appeal. Write down the date that you mailed it to TennCare.
	FAX: You can fax your appeal page or letter for free to 888-345-5575. Keep the paper that shows your fax went through.

For all medical appeals, TennCare needs:

1. Your **name** (the name of the person who wants to appeal about their care or medicine)
2. Your **Social Security number.** If you don't have the SSN number, give your date of birth. Include the month, day, and year.
3. The **address** where you get your mail.
4. The **name** of the person to call if TennCare has a question about your appeal (this can be you, or someone else).
5. 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 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:
    - An administrative judge
    - A TennCare lawyer
    - A witness for TennCare (someone like a doctor or nurse from TennCare),
    - 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. The letter will tell you what to do if you disagree with TennCare's decision.

Remember, you can find out more about your Rights to a Fair Hearing, in Part 7 of this handbook.

Eligibility Appeals - Getting or keeping TennCare and other TennCare problems

An appeal about TennCare problems *other than health care* is called an **eligibility appeal.** An eligibility appeal is filed with TennCare Connect and then goes to the Eligibility Appeals Unit at TennCare.

An eligibility 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 TennCare Connect at 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 Eligibility Appeal

Ways to File and Eligibility Appeal

Online: You can file an appeal through your account on TennCare Connect. Go to **tenncareconnect.tn.gov.**

CALL: You can call TennCare Connect for free at **855-259-0701** anytime from Monday through Friday.

MAIL: You can appeal **in writing.** You can write your appeal on plain paper.

Then, mail your letter about your problem to:

TennCare Connect
P.O. Box 305240
Nashville, TN 37230-5240

You can get an appeal page from our website. Go to the How to File an Eligibility Appeal web page and click on the Eligibility form in English or Spanish.

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

FAX: You can fax your appeal page or letter for free to 1-855-315-0669.

Keep the paper that shows your fax went through.

To file an eligibility 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** with 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.

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 BlueCare 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 BlueCare, its policies, its services, its caregivers, and members' rights and duties.
- Ask for and get information about how BlueCare pays its providers, including any kind of bonus for care based on cost or quality.
- Ask for and get information about your medical and insurance records as the federal and state laws say. You can see your medical and insurance records, get copies of your medical and insurance records, and ask to correct your medical and insurance records if they are wrong.
- Get services without being treated in a different way because of race, color, national origin, language, sex, age, religion, disability, or other groups protected by the civil rights laws. You have a right to report or file a written complaint if you think you have been treated differently. Being treated differently means you've been discriminated against. If you complain, you have the right to keep getting care without fear of bad treatment from BlueCare, providers, or TennCare. To file a complaint or learn more about your rights visit:

  https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html
- Get care without fear of physical restraint or seclusion used for bullying, discipline, convenience, or revenge.
- Make appeals or complaints about BlueCare or your care. Part 5 and Part 6 of this handbook tells you how.
- Make suggestions about your rights and responsibilities or how BlueCare works.
- Choose a PCP in the BlueCare 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 90 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 BlueCare to look again at any mistake you think they made.
- Ask 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 BlueCare or its providers treat you.
- BlueCare must make sure that its employees and contracted providers respect and protect members' rights.

Your rights to stay with BlueCare

As a BlueCare member, you **cannot** be moved from BlueCare 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 or substance use disorder) condition.
- Your special needs make you act in an uncooperative or disruptive way.

The only reasons you can be moved from BlueCare are:

- If you **change** health plans.
- If you **move** out of the BlueCare 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 BlueCare 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 BlueCare 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 BlueCare 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 the BlueCare 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 BlueCare ID card and let us know if it is lost or stolen.
- Tell TennCare Connect 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 BlueCare 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.

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 7 days. If you can't wait 7 days for the care you need, you can ask them to decide sooner. This is called an expedited prior authorization. Expedited prior authorizations must be decided in 72 hours.

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 the care you're getting, you should get a letter at least **10 days before** it happens. What if your **doctor** decides to change care you're getting? For the kinds of care listed below, **individuals under 21** should get a letter **2 business days before** it happens and **adults 21 and older** should get a letter **the day they are discharged**:

- Behavioral health (mental health or substance use disorder) 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 or substance use disorder) 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

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.

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.

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 **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 **888-345-5575.** 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.

You have the right to get a decision about your appeal within 90 days if it's not an emergency.

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 ten 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 the** 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.

TennCare Notice of Privacy Practices

Important: TennCare is required by the Federal Government to provide you with this Privacy Notice. This notice tells you how Personal Information about you may be used and shared. It also tells you how you can get access to and correct this information. Please review this notice carefully.

Your TennCare is not changing. You don't have to do anything.

This notice will tell you the following:

- The kinds of Personal Information we have,
- Why we collect it,
- How we collect it,
- How we share it,
- Who we share it with,
- How long we keep it,

- What to do if you don't want your information shared with certain people, and
- Your rights about your information.

What kinds of personal information we have:

When you applied for TennCare benefits you told us your name, about the people in your household, and where you live. You also told us your income and resources.

We get information from health care providers and federal or other state agencies to help with your application. We may also get other health facts like:

- A list of the health services and treatments you get,
- Notes or records from your doctor, drug store, hospital, or other health care providers,
- List of the medicine you take now or have taken before,
- Results from x-rays and lab tests, and
- 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).

Why we collect your Personal Information:

Federal and state laws allows us to collect, keep and use this information to provide you services. This is used to:

- Determine your eligibility for our programs,
- Work with our partners to provide you services, and
- Work to improve the services we provide you.

Federal and state laws say we must follow privacy rules to keep your Personal Information private. Everyone who works with us must also follow these privacy rules.

How we collect, use, or share your Personal Information:

In order to operate the Medicaid program, we may collect information about you and your household members from applications for services or from our partners. This may include:

- Federal agencies like Social Security Administration or the Internal Revenue Service.
- State departments like the Tennessee Department of Human Services, the Tennessee Department of Labor, or the Tennessee Department of Health
- TennCare partners like the Managed Care Organizations and providers.

Our websites may use cookies. These are small pieces of data placed on your hard drive to collect information you have entered. We use this information to help make our website easier for you to use and to improve how it works. You do not have to accept cookies from us, but if you choose not to, some of the functions on our site may not be available to you.

We can only use or share your Personal Information as the law allows us to.

When do we need your permission to share your Personal Information:

Sometimes we will need your permission in writing before we can share your Personal Information. We will ask you to sign a document giving us your permission if we need to use or share any of the following information:

- Notes a therapist takes during therapy sessions (they are called psychotherapy notes)
- Personal Information with companies who will use the information to try to get other people's business (for marketing purposes); and
- Personal Information with someone else for money.

Can you take back your permission? Yes, you can take back your permission, but you must tell us in writing. We also cannot take back the Personal Information we have already shared.

When do we NOT need your permission to share your Personal Information:

The privacy rules let us share your Personal Information *without asking for your permission* to people, or for purposes, including:

- You. We can help you find and schedule care 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.
- To show that you have TennCare coverage and to help you get the health care you need.
- To pay your health plan and health care providers.

- To improve the program and services we provide you.

We can share your Personal Information with people or organizations who work with TennCare, like:

- Health Care 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, in writing 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.

In some situations, the law also allows us to share your Personal Information with:

- 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 or investigative reasons. We can report fraud, 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. *We cannot 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 cannot share your genetic information to make decisions about your eligibility for TennCare.

How long do we keep your Personal Information?

TennCare will keep your Personal Information as long as it is needed to allow us to give you services and run the Medicaid program. We dispose of information as required by state and federal laws and regulations.

What if you don't want all of your Personal Information shared?

You must ask in writing if you do not want us to share your Personal Information. You must tell us the Personal Information you do not want shared

and who you do not want us to share it with. For example, you can ask us not to share Personal Information if:

- You paid for 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 will not share your Personal Information if you ask us. We will 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 cannot say OK, we will send you a letter that says why. What if you do not ask us to not share your Personal Information? We may use and share it only as explained in this notice.

Your rights about your Personal Information:

When it comes to your health information, you have certain rights. This section tells you about your rights and some of the ways we can help you.

Get an electronic or paper copy of your record

- You can ask to see or get a copy of your record and other health information we have about you. You must ask in writing.
- We can provide a copy or a summary of your information, usually within 30 days of your request.
- If your request is denied, we will tell you why, and tell you what your rights are.
- You may have to pay money for the cost of copying and mailing your copies

Communications

- You can ask us in writing to contact you in a different way or a different place. If writing or talking to you puts you in danger, tell us through the TN Safe at Home Program using the information below.

  Phone Number: 1-615-253-3043

  Website: https://sos.tn.gov/SafeAtHome

  Email Address: TNSOS.SAFE@TN.Gov
- You can ask us not to send you letters about fundraising.

Ask us to limit what we use or share

- You must ask us in writing if you do not want us to share your Personal Information.
- You must tell us what Personal Information you do not want shared and who you do not want us to share it with. For example:

- You paid for your care out of your own pocket, and
- You asked your doctor not to share your Personal Information for that care.

Get a list of those with whom we've shared information with outside of TennCare

You can ask in writing for a list of who we have shared your Personal Information with in the six years before the date of your request. But it will not list the times we have shared information when you have given us your permission, or other times when the law says we did not need to get your permission. For example, when we use Personal Information

- To help you get or pay for health care, or
- To run our program, or
- To give information to law enforcement if we are required to do so

Get a copy of this notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy as soon as possible.

Ask us to correct your record

You can ask us to change Personal Information that is wrong. You must ask in writing and tell us why we need to change it. If we cannot make the change, we will send a letter that tells you why.

TennCare's Responsibility to You:

TennCare must keep your Personal Information safe. We protect its privacy, security, and confidentiality. If your Personal Information gets out, we may have to tell you and federal authorities. We 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
- What we did to lower the risk that your Personal Information was misused.

Communications to you:

In compliance with the federal Telephone Consumer Protection Act, we and/or our partners like the health plans or providers, may call or text you, using an automatic telephone dialing system to tell you about treatment options or other health-related benefits and services. Tell us if you do not want to be contacted by phone.

You may also call 1-888-382-1222 or your health plan to add your phone number to the Do Not Call list.

Requests – Ask us in Writing:

Your requests must be in writing. We suggest sending a letter in the mail. Be sure you tell us what you're asking us to do. Write your name, date of birth and TennCare ID number *or* the last four digits of your Social Security Number on your letter. Send your letter to:

Division of TennCare
Attention: Privacy Office
310 Great Circle Road
Nashville, TN 37243

You can also contact us using email. If you want to use email, contact the TennCare Privacy Office first without including any sensitive information (like your date of birth or TennCare ID) so we can respond with a secure email portal. If you send an email with sensitive information without using a secure email portal, there is some risk that the personal information could be read or accessed by a third party.

Keep a copy of the letter for your records. Do you have questions? Do you need help making your request? Call TennCare Connect at **855-259-0701** for free.

Changes to this Notice:

TennCare's policies and procedures may change without notice. We will 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 or your health plan may send you these 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 in October 2023 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/. The latest version of this notice is found under "Notice of Privacy Practices."

Questions or Privacy Complaints

TennCare obeys federal and state civil rights laws. We don't discriminate, or treat people unfairly, because of their race, color, national origin, language, sex, age, disability, or other protected groups. 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 discriminated against? You can call TennCare Connect for free at 1-855-259-0701. Or you can write or call to:

Division of TennCare Attention: Privacy Office 310 Great Circle Road Nashville, TN 37243 Phone: 866-797-9469 Email: Privacy.TennCare@tn.gov	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: 866-627-7748 Website: www.hhs.gov/ocr/complaints

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 **BlueCare for free at 800-468-9698.**

Here are some other places that you can call or write to tell us about fraud and abuse:

Member Fraud:

Office of Inspector General (OIG)
P.O. Box 282368
Nashville, TN 37228
800-433-3982
https://www.tn.gov/finance/fa-oig/fa-oig-report-fraud.html

Provider Fraud:

TennCare Office of Program Integrity
Division of TennCare
Attn: Program Integrity Tip Department
310 Great Circle Road
Nashville, TN 37243
https://www.tn.gov/tenncare/fraud-and-abuse/program-integrity.html

Tennessee Bureau of Investigation (TBI)
Medicaid Fraud Control
901 R.S. Glass Blvd.
Nashville, TN 37216
800-433-5454
https://www.tn.gov/tenncare/fraud-and-abuse/program-integrity.html

Part 8: Healthcare papers you may need

Primary Care Provider (PCP) Change Request

To change your PCP online, log in to your BlueCare account. You can also request a paper form by calling 800-468-9698.

TennCare Discrimination Complaint Form

The TennCare Program does not discriminate, or treat people unfairly, because of their race, color, national origin including limited English proficiency and primary language, age, disability, religion, or sex. If you need reasonable modifications or think you were treated differently, or discriminated against, you can file a grievance (complaint) with TennCare's Office of Civil Rights Compliance by:

Email: HCFA.fairtreatment@tn.gov,
Online: https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html
Mail: 310 Great Circle Road Floor 3W, Nashville, TN 37243
Phone: 615-507-6474 (TRS 711).

Need help filing a grievance? Call TennCare Connect at 855-259-0701. To report a complaint to TennCare, go to:

English TennCare Discrimination Form

Spanish TennCare Discrimination Form

Arabic TennCare Discrimination Form

To request a paper copy, call 615-507-6474 or for free at 855-857-1673 (TRS 711).

Medical Appeal Form

Medical Service appeals are for problems like getting your health plan to OK a service your doctor says you need.

To file a medical appeal, complete the Member Medical Appeal Form:
https://www.tn.gov/content/dam/tn/tenncare/documents/medappeal.pdf

To request a paper copy of the form, call 1-800-878-3192.

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, complete the Expedited Appeal Providers Certificate:

ExpeditedAppealProvidersCertificate.pdf (tn.gov)

To request a paper copy of the form, call TennCare Member Medical Appeals for free at

1-800-878-3192.

Advanced Directives

The Tennessee Department of Health has made a single form that lets you tell your family and doctors what you want to happen with your healthcare and who you want to make decisions for your healthcare, if you become unable to decide for yourself. If you name an agent using this form, they may be allowed to make other decisions not related to medical care, unless you write on the form that they cannot. The Advance Directive for Health Care form can be found on:

https://www.tn.gov/content/dam/tn/health/documents/Advance_Directive_for_Health_Care.pdf

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 substance use disorder) 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

- 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.

Important: Co-payments are not required for preventive services.

TennCare Kids: Children and Teen Immunization Schedule

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger

UNITED STATES 2025

Vaccines and Other Immunizing Agents in the Child and Adolescent Immunization Schedule*

Monoclonal antibody	Abbreviation(s)	Trade name(s)
Respiratory syncytial virus monoclonal antibody (Nirsevimab)	RSV-mAb	Beyfortus
Vaccine	**Abbreviation(s)**	**Trade name(s)**
COVID-19 vaccine	1vCOV-mRNA	Comirnaty, mNexspike, Spikevax
	1vCOV-aPS	Nuvaxovid
Dengue vaccine	DEN4CYD	Dengvaxia
Diphtheria, tetanus, and acellular pertussis vaccine	DTaP	Daptacel Infanrix
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: egg-based)	IIV3	Multiple
Influenza vaccine (inactivated: cell-culture)	ccIIV3	Flucelvax
Influenza vaccine (live, attenuated)	LAIV3	FluMist
Measles, mumps, and rubella vaccine	MMR	M-M-R II Priorix
Meningococcal serogroups A, C, W, Y vaccine	MenACWY-CRM	Menveo
	MenACWY-TT	MenQuadfi
Meningococcal serogroup B vaccine	MenB-4C	Bexsero
	MenB-FHbp	Trumenba
Meningococcal serogroup A, B, C, W, Y vaccine	MenACWY-TT/ MenB-FHbp	Penbraya
Monkeypox vaccine	Mpox	Jynneos
Pneumococcal conjugate vaccine	PCV15 PCV20	Vaxneuvance Prevnar 20
Pneumococcal polysaccharide vaccine	PPSV23	Pneumovax 23
Poliovirus vaccine (inactivated)	IPV	Ipol
Respiratory syncytial virus vaccine	RSV	Abrysvo
Rotavirus vaccine	RV1 RV5	Rotarix RotaTeq
Tetanus, diphtheria, and acellular pertussis vaccine	Tdap	Adacel Boostrix
Tetanus and diphtheria vaccine	Td	Tenivac Tdvax
Varicella vaccine	VAR	Varivax
Combination vaccines *(use combination vaccines instead of separate injections when appropriate)*		
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
DTaP, inactivated poliovirus, *Haemophilus influenzae* type b, and hepatitis B vaccine	DTaP-IPV-Hib-HepB	Vaxelis
Measles, mumps, rubella, and varicella vaccine	MMRV	ProQuad

*Administer recommended vaccines if immunization history is incomplete or unknown. Do not restart or add doses to vaccine series for extended intervals between doses. When a vaccine is not administered at the recommended age, administer at a subsequent visit. The use of trade names is for identification purposes only and does not imply endorsement by ACIP or CDC.

Revised October 07, 2025

How to use the child and adolescent immunization schedule

1. Determine recommended vaccine by age **(Table 1)**
2. Determine recommended interval for catch-up vaccination **(Table 2)**
3. Assess need for additional recommended vaccines by medical condition or other indication **(Table 3)**
4. Review vaccine types, frequencies, intervals, and considerations for special situations **(Notes)**
5. Review contraindications and precautions for vaccine types **(Appendix)**
6. Review new or updated ACIP guidance **(Addendum)**

Report

- Suspected cases of reportable vaccine-preventable diseases or outbreaks to your state or local health department
- Clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov or 800-822-7967

Questions or comments

Contact www.cdc.gov/cdc-info or 800-CDC-INFO (800-232-4636), in English or Spanish, 8 a.m.–8 p.m. ET, Monday through Friday, excluding holidays.

Download the CDC Vaccine Schedules app for providers at www.cdc.gov/vaccines/hcp/imz-schedules/app.html

Helpful information

- Complete Advisory Committee on Immunization Practices (ACIP) recommendations: www.cdc.gov/acip-recs/hcp/vaccine-specific/index.html
- ACIP Shared Clinical Decision-Making Recommendations: www.cdc.gov/acip/vaccine-recommendations/shared-clinical-decision-making.html
- *General Best Practice Guidelines for Immunization* (including contraindications and precautions): www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html
- Vaccine information statements: www.cdc.gov/vaccines/hcp/vis/index.html
- Manual for the Surveillance of Vaccine-Preventable Diseases (including case identification and outbreak response): www.cdc.gov/surv-manual/php/

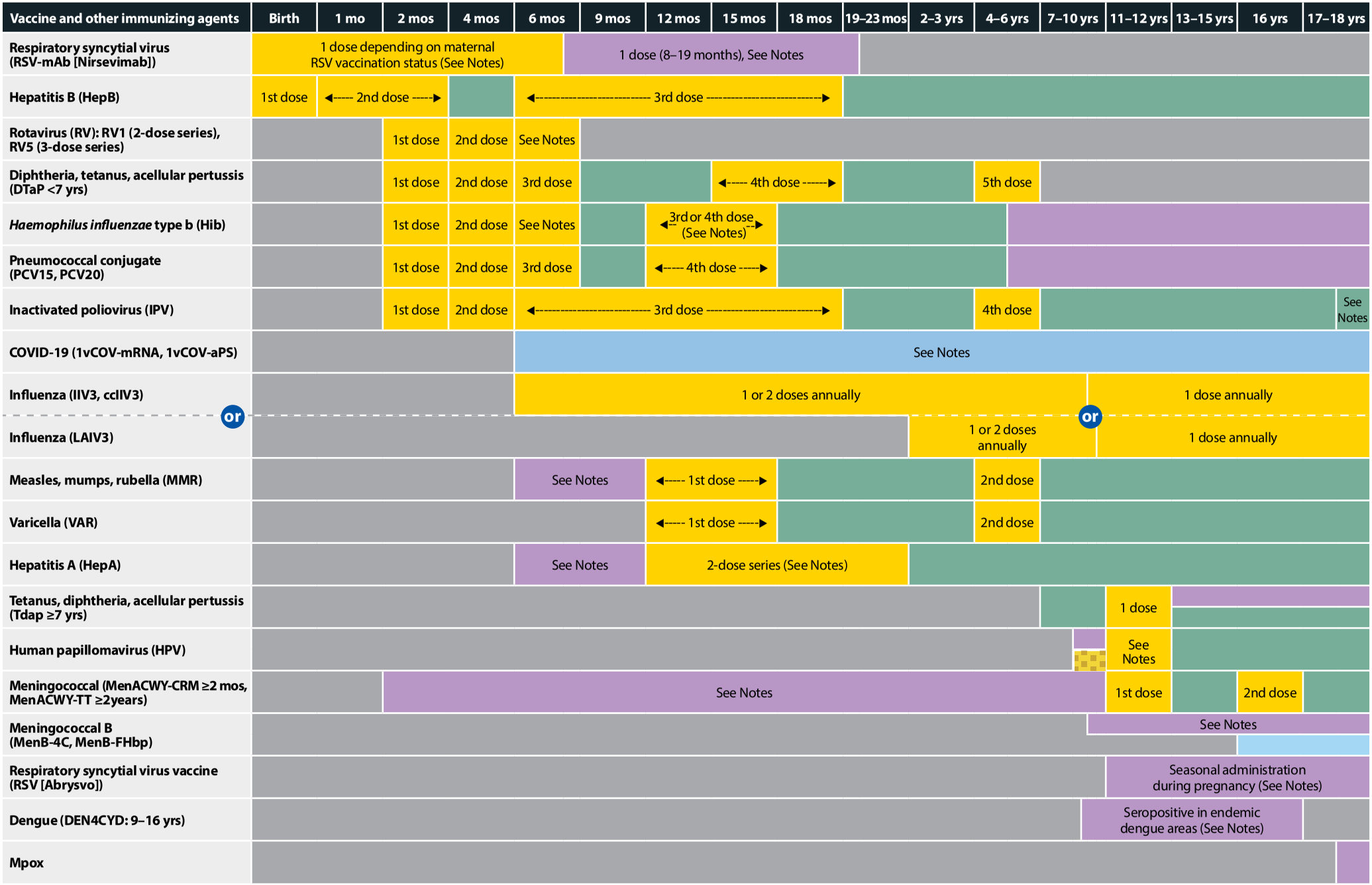
U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION

Scan QR code for access to online schedule

CS310020-E

Table 1 Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

These recommendations must be read with the notes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars.
To determine minimum intervals between doses, see the catch-up schedule (Table 2).



Range of recommended ages for all children
Range of recommended ages for catch-up vaccination
Range of recommended ages for certain high-risk groups or populations
Recommended vaccination can begin in this age group
Vaccination is based on shared clinical decision-making
No Guidance/ Not Applicable

Table 2 Recommended Catch-up Immunization Schedule for Children and Adolescents Who Start Late or Who Are More than 1 Month Behind, United States, 2025

The table 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 Table 1 and the Notes 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	Birth	**4 weeks**	**8 weeks *and* at least 16 weeks after first dose** minimum age for the final dose is 24 weeks		
Rotavirus	6 weeks Maximum age for first dose is 14 weeks, 6 days.	**4 weeks**	**4 weeks** maximum age for final dose is 8 months, 0 days		
Diphtheria, tetanus, and acellular pertussis	6 weeks	**4 weeks**	**4 weeks**	**6 months**	**6 months** A fifth dose is not necessary if the fourth dose was administered at age 4 years or older ***and*** at least 6 months after dose 3
Haemophilus influenzae type b	6 weeks	**No further doses needed** if first dose was administered at age 15 months or older. **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 previous dose was administered at age 15 months or older **4 weeks** 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), Vaxelis or unknown **8 weeks *and* age 12–59 months (as final dose)** if current age is younger than 12 months ***and*** first dose was administered at age 7–11 months; **OR** if current age is 12–59 months ***and*** first dose was administered before the 1st birthday ***and*** second dose was administered at younger than 15 months; **OR** if both doses were PedvaxHIB and were administered before the 1st birthday	**8 weeks (as final dose)** This dose only necessary for children age 12–59 months who received 3 doses before the 1st birthday.	
Pneumococcal conjugate	6 weeks	**No further doses needed** for healthy children if first dose was administered at age 24 months or older **4 weeks** if first dose was 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 previous dose was administered at age 24 months or older **4 weeks** if current age is younger than 12 months ***and*** previous dose was administered at <7 months old **8 weeks (as final dose for healthy children)** if previous dose was administered 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 administered before age 12 months	**8 weeks (as final dose)** This dose is only necessary for children age 12–59 months regardless of risk, or age 60–71 months with any risk, who received 3 doses before age 12 months.	
Inactivated poliovirus	6 weeks	**4 weeks**	**4 weeks** if current age is <4 years **6 months (as final dose)** if current age is 4 years or older	**6 months (minimum age 4 years for final dose)**	
Measles, mumps, rubella	12 months	**4 weeks**			
Varicella	12 months	**3 months**			
Hepatitis A	12 months	**6 months**			
Meningococcal ACWY	2 months MenACWY-CRM 2 years MenACWY-TT	**8 weeks**	See Notes	See Notes	
Children and adolescents age 7–18 years					
Meningococcal ACWY	Not applicable (N/A)	**8 weeks**			
Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis	7 years	**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	9 years	**Routine dosing intervals are recommended.**			
Hepatitis A	N/A	**6 months**			
Hepatitis B	N/A	**4 weeks**	**8 weeks *and* at least 16 weeks after first dose**		
Inactivated poliovirus	N/A	**4 weeks**	**6 months** 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	N/A	**4 weeks**			
Varicella	N/A	**3 months** if younger than age 13 years. **4 weeks** if age 13 years or older			
Dengue	9 years	**6 months**	6 months		

Table 3 Recommended Child and Adolescent Immunization Schedule by Medical Indication, United States, 2025

Always use this table in conjunction with Table 1 and the Notes that follow. Medical conditions are often not mutually exclusive. If multiple conditions are present, refer to guidance in all relevant columns. See Notes for medical conditions not listed.

Vaccine and other immunizing agents	Pregnancy	Immunocompromised (excluding HIV infection)	HIV infection CD4 percentage and count[a]		CSF leak or cochlear implant	Asplenia or persistent complement component deficiencies	Heart disease or chronic lung disease	Kidney failure, End-stage renal disease or on dialysis	Chronic liver disease	Diabetes
			<15% or <200/mm³	≥15% and ≥200/mm³						
RSV-mAb (nirsevimab)		2nd RSV season		1 dose depending on maternal RSV vaccination status (See Notes)			2nd RSV season for chronic lung disease (See Notes)	1 dose depending on maternal RSV vaccination status (See Notes)		
Hepatitis B										
Rotavirus		SCID[b]								
DTaP/Tdap	DTaP Tdap: 1 dose each pregnancy									
Hib		HSCT: 3 doses	See Notes			See Notes				
Pneumococcal										
IPV										
COVID-19	See Notes	Additional doses may be necessary (See Notes)		See Notes						
Influenza inactivated		Solid organ transplant: 18yrs (See Notes)								
LAIV3							Asthma, wheezing: 2–4 years[c]			
MMR	*									
VAR	*									
Hepatitis A										
HPV	*	3-dose series (See Notes)								
MenACWY										
MenB										
RSV (Abrysvo)	Seasonal administration (See Notes)									
Dengue										
Mpox	See Notes									

Recommended for all age-eligible children who lack documentation of a complete vaccination series

Not recommended for all children, but recommended for some children based on increased risk for or severe outcomes from disease

Vaccination is based on shared clinical decision-making

Additional doses may be necessary based on medical condition or other indications. See Notes.

Precaution: Might be indicated if benefit of protection outweighs risk of adverse reaction

Contraindicated or not recommended
*Vaccinate after pregnancy, if indicated

No Guidance/ Not Applicable

a. 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 J) at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.

b. Severe Combined Immunodeficiency

c. LAIV3 contraindicated for children 2–4 years of age with asthma or wheezing during the preceding 12 months

For vaccination recommendations for persons ages 19 years or older, see the Recommended Adult Immunization Schedule, 2025.

Additional information

- For calculating intervals between doses, 4 weeks = 28 days. Intervals of ≥4 months are determined by calendar months.
- Within a number range (e.g., 12–18), a dash (–) should be read as "through."
- Vaccine doses administered ≤4 days before the minimum age or interval are considered valid. Doses of any vaccine administered ≥5 days earlier than the minimum age or minimum interval should not be counted as valid and should be repeated as age appropriate. **The repeat dose should be spaced after the invalid dose by the recommended minimum interval.** For further details, see Table 3-2, Recommended and minimum ages and intervals between vaccine doses, in *General Best Practice Guidelines for Immunization* at www.cdc.gov/vaccines/hcp/imz-best-practices/timing-spacing-immunobiologics.html.
- Information on travel vaccination requirements and recommendations is available at www.cdc.gov/travel/.
- For vaccination of persons with immunodeficiencies, see Table 8-1, Vaccination of persons with primary and secondary immunodeficiencies, in *General Best Practice Guidelines for Immunization* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html, and Immunization in Special Clinical Circumstances (In: Kimberlin DW, Barnett ED, Lynfield Ruth, Sawyer MH, eds. *Red Book: 2021–2024 Report of the Committee on Infectious Diseases*. 32nd ed. Itasca, IL: American Academy of Pediatrics; 2021:72–86).
- For information about vaccination in the setting of a vaccine-preventable disease outbreak, contact your state or local health department.
- The National Vaccine Injury Compensation Program (VICP) is a no-fault alternative to the traditional legal system for resolving vaccine injury claims. All vaccines included in the child and adolescent vaccine schedule are covered by VICP except dengue, PPSV23, RSV, Mpox and COVID-19 vaccines. Mpox and COVID-19 vaccines are covered by the Countermeasures Injury Compensation Program (CICP). For more information, see www.hrsa.gov/vaccinecompensation or www.hrsa.gov/cicp.

COVID-19 vaccination (minimum age: 6 months [Spikevax], 5 years [Comirnaty], 12 years [mNexspike, Novaxovid])

Shared clinical decision-making

Vaccination based on individual-based decision-making —with an emphasis that the risk-benefit of vaccination is most favorable for individuals who are at an increased risk for severe COVID-19 disease and lowest for individuals who are not at an increased risk according to the CDC list of COVID-19 risk factors (see www.cdc.gov/covid/hcp/clinical-care/underlying-conditions.html). For additional information on shared clinical decision-making, see www.cdc.gov/acip/vaccine-recommendations/shared-clinical-decision-making.html

Current COVID-19 schedule and dosage formulation available at www.cdc.gov/covidschedule.

Administer an age-appropriate COVID-19 vaccine product for each dose. There is no preferential recommendation for the use of one COVID-19 vaccine over another when more than one recommended age-appropriate vaccine is available.

WHITE SPACE INTENTIONALLY LEFT BLANK

Dengue vaccination (minimum age: 9 years)

Routine vaccination

- Age 9–16 years living in areas with endemic dengue **AND** have laboratory confirmation of previous dengue infection
  - 3-dose series administered at 0, 6, and 12 months
- Endemic areas include Puerto Rico, American Samoa, US Virgin Islands, Federated States of Micronesia, Republic of Marshall Islands, and the Republic of Palau. For updated guidance on dengue endemic areas and pre-vaccination laboratory testing see www.cdc.gov/mmwr/volumes/70/rr/rr7006a1.htm?s_cid=rr7006a1_w and www.cdc.gov/dengue/index.html
- Dengue vaccine should not be administered to children traveling to or visiting endemic dengue areas.

Diphtheria, tetanus, and pertussis (DTaP) vaccination (minimum age: 6 weeks [4 years for Kinrix or Quadracel])

Routine vaccination

- 5-dose series (3-dose primary series at age 2, 4, and 6 months, followed by booster doses at ages 15–18 months and 4–6 years)
  - **Prospectively:** Dose 4 may be administered as early as age 12 months if at least 6 months have elapsed since dose 3.
  - **Retrospectively:** A 4th dose that was inadvertently administered as early as age 12 months may be counted if at least 4 months have elapsed since dose 3.

Catch-up vaccination

- Dose 5 is not necessary if dose 4 was administered at age 4 years or older and at least 6 months after dose 3.
- For other catch-up guidance, see Table 2.

Special situations

- **Children younger than age 7 years with a contraindication specific to the pertussis component of DTaP:** May administer Td for all recommended remaining doses in place of DTaP. Encephalopathy within 7 days of vaccination when not attributable to another identifiable cause is the only contraindication specific to the pertussis component of DTaP. For additional information, see www.cdc.gov/pertussis/hcp/vaccine-recommendations/td-offlabel.html.
- **Wound management in children younger than age 7 years with history of 3 or more doses of tetanus-toxoid-containing vaccine:** For all wounds except clean and minor wounds, administer DTaP if more than 5 years since last dose of tetanus-toxoid-containing vaccine. For detailed information, see www.cdc.gov/mmwr/volumes/67/rr/rr6702a1.htm.

Haemophilus influenzae type b vaccination
(minimum age: 6 weeks)

Routine vaccination

- **ActHIB, Hiberix, Pentacel, or Vaxelis:** 4-dose series (3-dose primary series at age 2, 4, and 6 months, followed by a booster dose* at age 12–15 months)
  - *Vaxelis is not recommended for use as a booster dose. A different Hib-containing vaccine should be used for the booster dose.
- **PedvaxHIB:** 3-dose series (2-dose primary series at age 2 and 4 months, followed by a booster dose at age 12–15 months)
- **American Indian and Alaska Native infants:** Vaxelis and PedvaxHIB preferred over other Hib vaccines for the primary series.

Catch-up vaccination

- **Dose 1 at age 7–11 months:** Administer dose 2 at least 4 weeks later and dose 3 (final dose) at age12–15 months or 8 weeks after dose 2 (whichever is later).
- **Dose 1 at age 12–14 months:** Administer dose 2 (final dose) at least 8 weeks after dose 1.
- **Dose 1 before age 12 months and dose 2 before age 15 months:** Administer dose 3 (final dose) at least 8 weeks after dose 2.
- **2 doses of PedvaxHIB before age 12 months:** Administer dose 3 (final dose) at age12–59 months and at least 8 weeks after dose 2.
- **1 dose administered at age 15 months or older:** No further doses needed
- **Unvaccinated at age 15–59 months:** Administer 1 dose.
- **Previously unvaccinated children age 60 months or older who are not considered high risk:** Catch-up vaccination not required.

For other catch-up guidance, see Table 2. Vaxelis can be used for catch-up vaccination in children younger than age 5 years. Follow the catch-up schedule even if Vaxelis is used for one or more doses. For detailed information on use of Vaxelis see www.cdc.gov/mmwr/volumes/69/wr/mm6905a5.htm.

Special situations

- **Chemotherapy or radiation treatment:**
  Age 12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

  Doses administered within 14 days of starting therapy or during therapy should be repeated at least 3 months after therapy completion.
- **Hematopoietic stem cell transplant (HSCT):**
  - 3-dose series 4 weeks apart starting 6 to 12 months after successful transplant, regardless of Hib vaccination history
- **Anatomic or functional asplenia (including sickle cell disease):**
  Age 12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

  Unvaccinated* persons age 5 years or older
  - 1 dose
- **Elective splenectomy:**
  Unvaccinated* persons age 15 months or older
  - 1 dose (preferably at least 14 days before procedure)
- **HIV infection:**
  Age 12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

  Unvaccinated* persons age 5–18 years
  - 1 dose
- **Immunoglobulin deficiency, early component complement deficiency, or early component complement inhibitor use:**
  Age 12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

Unvaccinated* = Less than routine series (through age 14 months) **or no doses (age 15 months or older)*

Hepatitis A vaccination
(minimum age: 12 months for routine vaccination)

Routine vaccination

- **2-dose series** (minimum interval: 6 months) at age 12–23 months

Catch-up vaccination

- **Unvaccinated persons through age 18 years should complete a 2-dose series** (minimum interval: 6 months).
- Persons who previously received 1 dose at age 12 months or older should receive dose 2 at least 6 months after dose 1.
- Adolescents age 18 years or older may receive HepA-HepB (Twinrix) as a 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months).

International travel

- Persons traveling to or working in countries with high or intermediate endemic hepatitis A (www.cdc.gov/travel/):
  - **Infants age 6–11 months**: 1 dose before departure; revaccinate with 2 doses (separated by at least 6 months) between age 12–23 months.
  - **Unvaccinated age 12 months or older**: Administer dose 1 as soon as travel is considered.

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Hepatitis B vaccination
(minimum age: birth)

Routine vaccination

- **Mother is HBsAg-negative**
  - 3-dose series at age 0, 1–2, 6–18 months **(use monovalent HepB vaccine for doses administered before age 6 weeks)**
    - Birth weight ≥2,000 grams: 1 dose within 24 hours of birth if medically stable
    - Birth weight <2,000 grams: 1 dose at chronological age 1 month or hospital discharge (whichever is earlier and even if weight is still <2,000 grams)
  - Infants who did not receive a birth dose should begin the series as soon as possible (see Table 2 for minimum intervals).
  - Administration of 4 doses is permitted when a combination vaccine containing HepB is used after the birth dose.
  - **Minimum intervals (see Table 2):** when 4 doses are administered, substitute "dose 4" for "dose 3" in these calculations.
  - **Final (3rd or 4th) dose:** age 6–18 months **(minimum age 24 weeks)**
- **Mother is HBsAg-positive**
  - **Birth dose (monovalent HepB vaccine only):** administer **HepB vaccine** and **hepatitis B immune globulin (HBIG)** in separate limbs within 12 hours of birth, regardless of birth weight.
  - **Birth weight <2000 grams:** administer 3 additional doses of HepB vaccine beginning at age 1 month (total of 4 doses).
  - **Final (3rd or 4th) dose:** administer at age 6 months **(minimum age 24 weeks)**.
  - Test for HBsAg and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose. Do not test before age 9 months.
- **Mother is HBsAg-unknown**

  If other evidence suggestive of maternal hepatitis B infection exists (e.g., presence of HBV DNA, HBeAg-positive, or mother known to have chronic hepatitis B infection), manage infant as if mother is HBsAg-positive.
  - **Birth dose (monovalent HepB vaccine only):**
    - Birth weight ≥2,000 grams: administer **HepB vaccine** within 12 hours of birth. Determine mother's HBsAg status as soon as possible. If mother is determined to be HBsAg-positive, administer **HBIG** as soon as possible (in separate limb), but no later than 7 days of age.
    - Birth weight <2,000 grams: administer **HepB vaccine** and **HBIG** (in separate limbs) within 12 hours of birth. Administer 3 additional doses of **HepB vaccine** beginning at age 1 month (total of 4 doses).
  - **Final (3rd or 4th) dose:** administer at age 6 months **(minimum age 24 weeks)**.
  - If mother is determined to be HBsAg-positive or if status remains unknown, test for HBsAg and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose. Do not test before age 9 months.

Catch-up vaccination

- Unvaccinated persons should complete a 3-dose series at 0, 1–2, 6 months. See Table 2 for minimum intervals.
- Adolescents age 11–15 years may use an alternative 2-dose schedule with at least 4 months between doses (adult formulation **Recombivax HB** only).
- Adolescents age 18 years may receive:
  - **Heplisav-B:** 2-dose series at least 4 weeks apart
  - **PreHevbrio*:** 3-dose series at 0, 1, and 6 months
  - **HepA-HepB (Twinrix):** 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months).

Special situations

- Revaccination is generally not recommended for persons with a normal immune status who were vaccinated as infants, children, adolescents, or adults.
- **Post-vaccination serology testing and revaccination** (if anti-HBs <10mIU/mL) is recommended for certain populations, including:
  - Infants born to HBsAg-positive mothers
  - Persons who are predialysis or on maintenance dialysis
  - Other immunocompromised persons
  - For detailed revaccination recommendations, see www.cdc.gov/mmwr/volumes/67/rr/rr6701a1.htm.

***Note:** PreHevbrio is not recommended in pregnancy due to lack of safety data in pregnant women.

Human papillomavirus vaccination
(minimum age: 9 years)

Routine and catch-up vaccination

- HPV vaccination routinely recommended at **age 11–12 years (can start at age 9 years)** and catch-up HPV vaccination recommended for all persons through age 18 years if not adequately vaccinated.
- 2- or 3-dose series depending on age at initial vaccination:
  - **Age 9–14 years at initial vaccination**: 2-dose series at 0, 6–12 months (minimum interval: 5 months; repeat dose if administered too soon)
  - **Age 15 years or older at initial vaccination**: 3-dose series at 0, 1–2 months, 6 months (minimum intervals: dose 1 to dose 2 = 4 weeks; dose 2 to dose 3 = 12 weeks; dose 1 to dose 3 = 5 months; repeat dose if administered too soon)
- No additional dose recommended when any HPV vaccine series **of any valency** has been completed using recommended dosing intervals.

Special situations

- **Immunocompromising conditions, including HIV infection:** 3-dose series, even for those who initiate vaccination at age 9–14 years.
- **History of sexual abuse or assault:** Start at age 9 years
- **Pregnancy:** Pregnancy testing not needed before vaccination; HPV vaccination not recommended until after pregnancy; no intervention needed if vaccinated while pregnant

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Influenza vaccination
(minimum age: 6 months [IIV3], 2 years [LAIV3],18 years [recombinant influenza vaccine, RIV3])

Routine vaccination

- Use any influenza vaccine appropriate for age and health status annually:
  - **Age 6 months–8 years** who have received fewer than 2 influenza vaccine doses before July 1, 2024, or whose influenza vaccination history is unknown: 2 doses, separated by at least 4 weeks. Administer dose 2 even if the child turns 9 years between receipt of dose 1 and dose 2.
  - **Age 6 months–8 years** who have received at least 2 influenza vaccine doses before July 1, 2024: 1 dose.
  - **Age 9 years or older:** 1 dose
  - **Age 18 years solid organ transplant recipients receiving immunosuppressive medications:** high-dose inactivated (HD-IIV3) and adjuvanted inactivated (aIIV3) influenza vaccines are acceptable options. No preference over other age-appropriate IIV3 or RIV3.
- For the 2024–25 season, see www.cdc.gov/mmwr/volumes/73/rr/rr7305a1.htm.
- For the 2025–26 season, see the 2025–26 ACIP influenza vaccine recommendations.

Special situations

- **Close contacts (e.g., household contacts) of severely immunosuppressed persons who require a protected environment:** should not receive LAIV3. If LAIV3 is given, they should avoid contact with, or caring for such immunosuppressed persons for 7 days after vaccination.

Note: Persons with an egg allergy can receive any influenza vaccine (egg-based or non-egg based) appropriate for age and health status.

Measles, mumps, and rubella vaccination
(minimum age: 12 months for routine vaccination)

Routine vaccination

- 2-dose series at age 12–15 months, age 4–6 years

Catch-up vaccination

- **Unvaccinated children and adolescents:** 2-dose series at least 4 weeks apart*

Special situations

- **International travel**
  - **Infants age 6–11 months:** 1 dose before departure; revaccinate with 2-dose series at age 12–15 months (12 months for children in high-risk areas) and dose 2 as early as 4 weeks later.*
  - **Children age 12 months or older:**
    - Unvaccinated: 2-dose series (separated by at least 4 weeks*) before departure
    - Previously received 1 dose: administer dose 2 at least 4 weeks after dose 1*
- In mumps outbreak settings, for information about additional doses of MMR (including 3rd dose of MMR), see www.cdc.gov/mmwr/volumes/67/wr/mm6701a7.htm

***Note:** MMRV not recommended for ages 12–47 months or ages 13–18 years. Minimum interval between MMRV doses is 3 months.

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Meningococcal serogroup A,C,W,Y vaccination
(minimum age: 2 months [MenACWY-CRM, Menveo], 2 years [MenACWY-TT, MenQuadfi]), 10 years [MenACWY-TT/MenB-FHbp, Penbraya])

Routine vaccination

- 2-dose series at age 11–12 years; 16 years

Catch-up vaccination

- **Age 13–15 years:** 1 dose now and booster at age 16–18 years (minimum interval: 8 weeks)
- **Age 16–18 years:** 1 dose

Special situations

Anatomic or functional asplenia (including sickle cell disease), HIV infection, persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:

- **Menveo***
  - Dose 1 at age 2 months: 4-dose series (additional 3 doses at age 4, 6, and 12 months)
  - Dose 1 at age 3–6 months: 3- or 4-dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 12 months)
  - Dose 1 at age 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after age 12 months)
  - Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart
- **MenQuadfi**
  - Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart

Travel to countries with hyperendemic or epidemic meningococcal disease, including countries in the African meningitis belt or during the Hajj (www.cdc.gov/travel/):

- **Children younger than age 24 months:**
  - **Menveo* (age 2–23 months)**
    - Dose 1 at age 2 months: 4-dose series (additional 3 doses at age 4, 6, and 12 months)
    - Dose 1 at age 3–6 months: 3- or 4-dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 12 months)
    - Dose 1 at age 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after age 12 months)

Meningococcal serogroup A,C,W,Y vaccination - *continued*

- **Children age 2 years or older:** 1 dose Menveo* or MenQuadfi

First-year college students who live in residential housing (if not previously vaccinated at age 16 years or older) or military recruits: 1 dose Menveo* or MenQuadfi

Adolescent vaccination of children who received MenACWY prior to age 10 years:

- **Children for whom boosters are recommended because of an ongoing increased risk of meningococcal disease** (e.g., those with complement component deficiency, HIV, or asplenia): Follow the booster schedule for persons at increased risk.
- **Children for whom boosters are not recommended** (e.g., a healthy child who received a single dose for travel to a country where meningococcal disease is endemic): Administer MenACWY according to the recommended adolescent schedule with dose 1 at age 11–12 years and dose 2 at age 16 years.

**Menveo has two formulations: lyophilized and liquid. The liquid formulation should not be used before age 10 years. See www.cdc.gov/vaccines/vpd/mening/downloads/menveo-single-vial-presentation.pdf.*

Note: For MenACWY **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

Children age 10 years or older may receive a single dose of Penbraya as an alternative to separate administration of MenACWY and MenB when both vaccines would be given on the same clinic day (see "Meningococcal serogroup B vaccination" section below for more information).

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Meningococcal serogroup B vaccination (minimum age: 10 years [MenB-4C, Bexsero; MenB-FHbp, Trumenba; MenACWY-TT/MenB-FHbp, Penbraya])

Shared clinical decision-making

- **Adolescents not at increased risk age 16–23 years (preferred age 16–18 years)* based on shared clinical decision-making.**
  - **Bexsero or Trumenba (use same brand for all doses):** 2-dose series at least 6 months apart (if dose 2 is administered earlier than 6 months, administer dose 3 at least 4 months after dose 2)

*To optimize rapid protection (e.g., for students starting college in less than 6 months), a 3-dose series (0, 1–2, 6 months) may be administered.

For additional information on shared clinical decision-making for MenB, see www.cdc.gov/vaccines/hcp/admin/downloads/isd-job-aid-scdm-mening-b-shared-clinical-decision-making.pdf

Special situations

Anatomic or functional asplenia (including sickle cell disease), persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use.

- **Bexsero or Trumenba (use same brand for all doses including booster doses)** 3-dose series at 0, 1–2, 6 months (if dose 2 was administered at least 6 months after dose 1, dose 3 not needed; if dose 3 is administered earlier than 4 months after dose 2, a 4th dose should be administered at least 4 months after dose 3)

For MenB **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

Note: MenB vaccines may be administered simultaneously with MenACWY vaccines if indicated, but at a different anatomic site, if feasible.

Children age 10 years or older may receive a dose of Penbraya (MenACWY–TT/MenB–FHbp) as an alternative to separate administration of MenACWY and MenB when both vaccines would be given on the same clinic day. For age-eligible children not at increased risk, if Penbraya is used for dose 1 MenB, MenB-FHbp (Trumenba) should be administered for dose 2 MenB. For age-eligible children at increased risk of meningococcal disease, Penbraya may be used for additional MenACWY and MenB doses (including booster doses) if both would be given on the same clinic day **and** at least 6 months have elapsed since most recent Penbraya dose.

Monkeypox virus vaccination (minimum age: 18 years [Jynneos])

Special situations

- **Age 18 years and at risk for monkeypox infection:** complete 2-dose series, 28 days apart.

  Risk factors for monkeypox infection include:
  - Gay, bisexual, or other MSM, or a person who has sex with gay, bisexual, or other MSM who in the past 6 months have had one of the following:
    - A new diagnosis of at least 1 sexually transmitted disease
    - More than 1 sex partner
    - Sex at a commercial sex venue
    - Sex in association with a large public event in a geographic area where monkeypox virus transmission is occurring
  - Persons who are sexual partners of the persons described above
  - Persons who anticipate experiencing any of the situations described above
- **Pregnancy:** There is currently no ACIP recommendation for Jynneos use in pregnancy due to lack of safety data in pregnant women. Pregnant women with any risk factor described above may receive Jynneos.

For detailed information, see www.cdc.gov/mpox/hcp/vaccine-considerations/vaccination-overview.html

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Pneumococcal vaccination
(minimum age: 6 weeks [PCV15], [PCV 20]; 2 years [PPSV23])

Routine vaccination with PCV

- 4-dose series at 2, 4, 6, 12–15 months

Catch-up vaccination with PCV

- Healthy children ages 2–4 years with any incomplete* PCV series: 1 dose PCV
- For other catch-up guidance, see Table 2.

Note: For children **without** risk conditions, PCV20 is not indicated if they have received 4 doses of PCV13 or PCV15 or another age appropriate complete PCV series.

Special situations

Children and adolescents with cerebrospinal fluid leak; chronic heart disease; chronic kidney disease (excluding maintenance dialysis and nephrotic syndrome); chronic liver disease; chronic lung disease (including moderate persistent or severe persistent asthma); cochlear implant; or diabetes mellitus:

Age 2–5 years

- Any incomplete* PCV series with:
  - 3 PCV doses: 1 dose PCV (at least 8 weeks after the most recent PCV dose)
  - Less than 3 PCV doses: 2 doses PCV (at least 8 weeks after the most recent dose and administered at least 8 weeks apart)
- Completed recommended PCV series but have not received PPSV23.
  - Previously received at least 1 dose of PCV20: no further PCV or PPSV23 doses needed
  - Not previously received PCV20: administer 1 dose PCV20 or 1 dose PPSV23 administer at least 8 weeks after the most recent PCV dose.

Age 6–18 years

- Not previously received any dose of PCV13, PCV15, or PCV20: administer 1 dose of PCV15 or PCV20. If PCV15 is used and no previous receipt of PPSV23, administer 1 dose of PPSV23 at least 8 weeks after the PCV15 dose.**
- Received PCV before age 6 years but have not received PPSV23
  - Previously received at least 1 dose of PCV20: no further PCV or PPSV23 doses needed
  - Not previously received PCV20: 1 dose PCV20 or 1 dose PPSV23 administer at least 8 weeks after the most recent PCV dose.
- Received PCV13 only at or after age 6 years: administer 1 dose PCV20 or 1 dose PPSV23 at least 8 weeks after the most recent PCV13 dose.
- Received 1 dose PCV13 and 1 dose PPSV23 at or after age 6 years: no further doses of any PCV or PPSV23 indicated.

Children and adolescents on maintenance dialysis, or with immunocompromising conditions such as nephrotic syndrome; congenital or acquired asplenia or splenic dysfunction; congenital or acquired immunodeficiencies; diseases and conditions treated with immunosuppressive drugs or radiation therapy, including malignant neoplasms, leukemias, lymphomas, Hodgkin disease, and solid organ transplant; HIV infection; or sickle cell disease or other hemoglobinopathies:

Age 2–5 years

- Any incomplete* PCV series:
  - 3 PCV doses: 1 dose PCV (at least 8 weeks after the most recent PCV dose)
  - Less than 3 PCV doses: 2 doses PCV (at least 8 weeks after the most recent dose and administered at least 8 weeks apart)
- Completed recommended PCV series but have not received PPSV23
  - Previously received at least 1 dose of PCV20: no further PCV or PPSV23 doses needed
  - Not previously received PCV20: administer 1 dose PCV20 or 1 dose PPSV23 at least 8 weeks after the most recent PCV dose. If PPSV23 is used, administer 1 dose of PCV20 or dose 2 PPSV23 at least 5 years after dose 1 PPSV23.

Age 6–18 years

- Not previously received any dose of PCV13, PCV15, or PCV20: administer 1 dose of PCV15 or 1 dose of PCV20. If PCV15 is used and no previous receipt of PPSV23, administer 1 dose of PPSV23 at least 8 weeks after the PCV15 dose.**
- Received PCV before age 6 years but have not received PPSV23
  - Previously received at least 1 dose of PCV20: no additional dose of PCV or PPSV23
  - Not previously received PCV20: administer 1 dose PCV20 or 1 dose PPSV23 at least 8 weeks after the most recent PCV dose. If PPSV23 is used, administer either PCV20 or dose 2 PPSV23 at least 5 years after dose 1 PPSV23.
- Received PCV13 only at or after age 6 years: administer 1 dose PCV20 or 1 dose PPSV23 at least 8 weeks after the most recent PCV13 dose. If PPSV23 is used, administer 1 dose of PCV20 or dose 2 PPSV23 at least 5 years after dose 1 PPSV23.
- Received 1 dose PCV13 and 1 dose PPSV23 at or after age 6 years: administer 1 dose PCV20 or 1 dose PPSV23 at least 8 weeks after the most recent PCV13 dose and at least 5 years after dose 1 PPSV23.

Pregnancy: no recommendation for PCV or PPSV23 due to limited data. Summary of existing data on pneumococcal vaccination during pregnancy can be found at www.cdc.gov/mmwr/volumes/72/rr/rr7203a1.htm

For guidance on determining which pneumococcal vaccines a patient needs and when, please refer to the mobile app, which can be downloaded here: wcms-wp.cdc.gov/pneumococcal/hcp/vaccine-recommendations/app.html

**Incomplete series* = Not having received all doses in either the recommended series or an age-appropriate catch-up series. See Table 2 in ACIP pneumococcal recommendations at stacks.cdc.gov/view/cdc/133252

***When both PCV15 and PPSV23 are indicated, administer all doses of PCV15 first. PCV15 and PPSV23 should not be administered during the same visit.*

Poliovirus vaccination
(minimum age: 6 weeks)

Routine vaccination

- 4-dose series at ages 2, 4, 6–18 months, 4–6 years; administer the final dose on or after age 4 years and at least 6 months after the previous dose.
- 4 or more doses of IPV can be administered before age 4 years when a combination vaccine containing IPV is used. However, a dose is still recommended on or after age 4 years and at least 6 months after the previous dose.

Catch-up vaccination

- In the first 6 months of life, use minimum ages and intervals only for travel to a polio-endemic region or during an outbreak.
- **Adolescents age 18 years known or suspected to be unvaccinated or incompletely vaccinated:** administer remaining doses (1, 2, or 3 IPV doses) to complete a 3-dose primary series.* Unless there are specific reasons to believe they were not vaccinated, most persons aged 18 years or older born and raised in the United States can assume they were vaccinated against polio as children.

Series containing oral poliovirus vaccine (OPV), either mixed OPV-IPV or OPV-only series:

- Total number of doses needed to complete the series is the same as that recommended for the U.S. IPV schedule. See www.cdc.gov/mmwr/volumes/66/wr/mm6601a6.htm?s_%20cid=mm6601a6_w.
- Only trivalent OPV (tOPV) counts toward the U.S. vaccination requirements.
  - Doses of OPV administered before April 1, 2016, should be counted (unless specifically noted as administered during a campaign).
  - Doses of OPV administered on or after April 1, 2016, should not be counted.
  - For guidance to assess doses documented as "OPV," see www.cdc.gov/mmwr/volumes/66/wr/mm6606a7.htm?s_cid=mm6606a7_w.
- For other catch-up guidance, see Table 2.

Special situations

- **Adolescents aged 18 years at increased risk of exposure to poliovirus and completed primary series*:** may administer one lifetime IPV booster

***Note:** Complete primary series consist of at least 3 doses of IPV or trivalent oral poliovirus vaccine (tOPV) in any combination.

For detailed information, see: www.cdc.gov/vaccines/vpd/polio/hcp/recommendations.html

Respiratory syncytial virus immunization
(minimum age: birth [Nirsevimab, RSV-mAb, Beyfortus])

Routine immunization

- **Infants born October – March in most of the continental United States***
  - Mother did not receive RSV vaccine or mother's RSV vaccination status is unknown or mother received RSV vaccine in previous pregnancy: administer 1 dose nirsevimab within 1 week of birth—ideally during the birth hospitalization.
  - Mother received RSV vaccine **less than 14 days** prior to delivery: administer 1 dose nirsevimab within 1 week of birth—ideally during the birth hospitalization.
  - Mother received RSV vaccine **at least 14 days** prior to delivery: nirsevimab not needed but can be considered in rare circumstances at the discretion of healthcare providers (see www.cdc.gov/vaccines/vpd/rsv/hcp/child-faqs.html)
- **Infants born April–September in most of the continental United States***
  - Mother did not receive RSV vaccine or mother's RSV vaccination status is unknown or mother received RSV vaccine in previous pregnancy: administer 1 dose nirsevimab shortly before start of RSV season.*
  - Mother received RSV vaccine **less than 14 days** prior to delivery: administer 1 dose nirsevimab shortly before start of RSV season.*
  - Mother received RSV vaccine **at least 14 days** prior to delivery: nirsevimab not needed but can be considered in rare circumstances at the discretion of healthcare providers (see www.cdc.gov/vaccines/vpd/rsv/hcp/child-faqs.html)

Infants with prolonged birth hospitalization** (e.g., for prematurity) discharged October through March should be immunized shortly before or promptly after discharge.

Special situations

- **Ages 8–19 months with chronic lung disease of prematurity requiring medical support (e.g., chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) any time during the 6-month period before the start of the second RSV season; severe immunocompromise; cystic fibrosis with either weight for length <10th percentile or manifestation of severe lung disease (e.g., previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest imaging that persist when stable)**:**
  - 1 dose nirsevimab shortly before start of second RSV season*
- **Ages 8–19 months who are American Indian or Alaska Native:** 1 dose nirsevimab shortly before start of second RSV season*
- **Age-eligible and undergoing cardiac surgery with cardiopulmonary bypass**:** 1 additional dose of nirsevimab after surgery. See www.accessdata.fda.gov/drugsatfda_docs/label/2023/761328s000lbl.pdf

***Note:** While the timing of the onset and duration of RSV season may vary, administration of nirsevimab is recommended October through March in most of the continental United States (optimally October through November or within 1 week of birth). Providers in jurisdictions with RSV seasonality that differs from most of the continental United States (e.g., Alaska, jurisdiction with tropical climate) should follow guidance from public health authorities (e.g., CDC, health departments) or regional medical centers on timing of administration based on local RSV seasonality.

****Note:** Nirsevimab can be administered to children who are eligible to receive palivizumab. Children who have received nirsevimab should not receive palivizumab for the same RSV season.

For further guidance, see www.cdc.gov/mmwr/volumes/72/wr/mm7234a4.htm and www.cdc.gov/vaccines/vpd/rsv/hcp/child-faqs.html

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Respiratory syncytial virus vaccination (RSV [Abrysvo])

Routine vaccination

- **Pregnant at 32 weeks 0 days through 36 weeks and 6 days gestation from September through January in most of the continental United States*:** 1 dose Abrysvo. Administer RSV vaccine regardless of previous RSV infection.
  - Either maternal RSV vaccination with Abrysvo or infant immunization with nirsevimab (RSV monoclonal antibody) is recommended to prevent severe respiratory syncytial virus disease in infants.
- **All other pregnant women:** RSV vaccine not recommended
- **Subsequent pregnancies:** additional doses not recommended. No data are available to inform whether additional doses are needed in subsequent pregnancies. Infants born to pregnant women who received RSV vaccine during a previous pregnancy should receive nirsevimab.

***Note:** Providers in jurisdictions with RSV seasonality that differs from most of the continental United States (e.g., Alaska, jurisdictions with tropical climate) should follow guidance from public health authorities (e.g., CDC, health departments) or regional medical centers on timing of administration based on local RSV seasonality.

Rotavirus vaccination (minimum age: 6 weeks)

Routine vaccination

- **Rotarix:** 2-dose series at age 2 and 4 months
- **RotaTeq:** 3-dose series at age 2, 4, and 6 months
- If any dose in the series is either **RotaTeq** or unknown, default to 3-dose series.

Catch-up vaccination

- Do not start the series on or after age 15 weeks, 0 days.
- The maximum age for the final dose is 8 months, 0 days.
- For other catch-up guidance, see Table 2.

Tetanus, diphtheria, and pertussis (Tdap) vaccination (minimum age: 11 years for routine vaccination, 7 years for catch-up vaccination)

Routine vaccination

- **Age 11–12 years:** 1 dose Tdap (adolescent booster)
- **Pregnancy:** 1 dose Tdap during each pregnancy, preferably in early part of gestational weeks 27–36

Note: Tdap may be administered regardless of the interval since the last tetanus- and diphtheria-toxoid-containing vaccine.

Catch-up vaccination

- **Age 13–18 years who have not received Tdap:** 1 dose Tdap (adolescent booster)
- **Age 7–18 years not fully vaccinated* with DTaP:** 1 dose Tdap as part of the catch-up series (preferably the first dose); if additional doses are needed, use Td or Tdap.
- **Tdap administered at age 7–10 years:**
  - **Age 7–9 years** who receive Tdap should receive the adolescent Tdap booster dose at age 11–12 years
  - **Age 10 years** who receive Tdap do not need the adolescent Tdap booster dose at age 11–12 years
- **DTaP inadvertently administered on or after age 7 years**:
  - **Age 7–9 years**: DTaP may count as part of catch-up series. Administer adolescent Tdap booster dose at age 11–12 years.
  - **Age 10–18 years**: Count dose of DTaP as the adolescent Tdap booster dose.
- For other catch-up guidance, see Table 2.

Special situations

- **Wound management** in persons age 7 years or older with history of 3 or more doses of tetanus-toxoid-containing vaccine: For clean and minor wounds, administer Tdap or Td if more than 10 years since last dose of tetanus-toxoid-containing vaccine; for all other wounds, administer Tdap or Td if more than 5 years since last dose of tetanus-toxoid-containing vaccine. Tdap is preferred for persons age 11 years or older who have not previously received Tdap or whose Tdap history is unknown. If a tetanus-toxoid-containing vaccine is indicated for a pregnant adolescent, use Tdap.
- For detailed information, see www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.htm.

**Fully vaccinated* = 5 valid doses of DTaP or 4 valid doses of DTaP if dose 4 was administered at age 4 years or older

Varicella vaccination (minimum age: 12 months)

Routine vaccination

- 2-dose series at age 12–15 months, 4–6 years
  - Dose 2 may be administered as early as 3 months after dose 1 (a dose inadvertently administered after at least 4 weeks may be counted as valid).

Catch-up vaccination

- Ensure persons age 7–18 years without evidence of immunity (see *MMWR* at www.cdc.gov/mmwr/pdf/rr/rr5604.pdf) have a 2-dose series:
  - **Age 7–12 years**: Routine interval: 3 months (a dose inadvertently administered after at least 4 weeks may be counted as valid)
  - **Age 13 years and older**: Routine interval: 4–8 weeks (minimum interval: 4 weeks)

Note: MMRV not recommended for ages 12–47 months or ages 13–18 years (administer MMR and varicella vaccines separately for these age groups). Minimum interval between MMRV doses is 3 months.

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Appendix Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

Guide to Contraindications and Precautions to Commonly Used Vaccines

Adapted from Table 4-1 in Advisory Committee on Immunization Practices (ACIP) General Best Practice Guidelines for Immunization: Contraindication and Precautions, Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices—United States, 2024–25 Influenza Season | MMWR (cdc.gov), *and* Contraindications and Precautions for COVID-19 Vaccination

Vaccines and other Immunizing Agents	Contraindicated or Not Recommended[1]	Precautions[2]
COVID-19 mRNA vaccines [Comirnaty, mNexspike, Spikevax]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of an mRNA COVID-19 vaccine[3]	• Diagnosed non-severe allergy (e.g., urticaria beyond the injection site) to a component of an mRNA COVID-19 vaccine[3]; or non-severe, immediate (onset less than 4 hours) allergic reaction after administration of a previous dose of an mRNA COVID-19 vaccine • Myocarditis or pericarditis within 3 weeks after a dose of any COVID-19 vaccine • Multisystem inflammatory syndrome in children (MIS-C) or multisystem inflammatory syndrome in adults (MIS-A) • Moderate or severe acute illness, with or without fever
COVID-19 protein subunit vaccine [Nuvaxovid]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of a Nuvaxovid[3]	• Diagnosed non-severe allergy (e.g., urticaria beyond the injection site) to a component of Nuvaxovid[3]; or non-severe, immediate (onset less than 4 hours) allergic reaction after administration of a previous dose of a Nuvaxovid • Myocarditis or pericarditis within 3 weeks after a dose of any COVID-19 vaccine • Multisystem inflammatory syndrome in children (MIS-C) or multisystem inflammatory syndrome in adults (MIS-A) • Moderate or severe acute illness, with or without fever
Influenza, egg-based, inactivated injectable (IIV3)	• Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, ccIIV, RIV, or LAIV of any valency) • Severe allergic reaction (e.g., anaphylaxis) to any vaccine component[3] (excluding egg)	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Moderate or severe acute illness with or without fever
Influenza, cell culture-based inactivated injectable (ccIIV3) [Flucelvax]	• Severe allergic reaction (e.g., anaphylaxis) to any ccIIV of any valency, or to any component[3] of ccIIV3	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Persons with a history of severe allergic reaction (e.g., anaphylaxis) after a previous dose of any egg-based IIV, RIV, or LAIV of any valency. If using ccIIV3, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Moderate or severe acute illness with or without fever
Influenza, recombinant injectable (RIV3) [Flublok]	• Severe allergic reaction (e.g., anaphylaxis) to any RIV of any valency, or to any component[3] of RIV3	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Persons with a history of severe allergic reaction (e.g., anaphylaxis) after a previous dose of any egg-based IIV, ccIIV, or LAIV of any valency. If using RIV3, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Moderate or severe acute illness with or without fever
Influenza, live attenuated (LAIV3) [Flumist]	• Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, ccIIV, RIV, or LAIV of any valency) • Severe allergic reaction (e.g., anaphylaxis) to any vaccine component[3] (excluding egg) • Children age 2–4 years with a history of asthma or wheezing • Anatomic or functional asplenia • Immunocompromised due to any cause including, but not limited to, medications and HIV infection • Close contacts or caregivers of severely immunosuppressed persons who require a protected environment • Pregnancy • Cochlear implant • Active communication between the cerebrospinal fluid (CSF) and the oropharynx, nasopharynx, nose, ear or any other cranial CSF leak • Children and adolescents receiving aspirin or salicylate-containing medications • Received influenza antiviral medications oseltamivir or zanamivir within the previous 48 hours, peramivir within the previous 5 days, or baloxavir within the previous 17 days	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Asthma in persons age 5 years old or older • Persons with underlying medical conditions other than those listed under contraindications that might predispose to complications after wild-type influenza virus infection, e.g., chronic pulmonary, cardiovascular (except isolated hypertension), renal, hepatic, neurologic, hematologic, or metabolic disorders (including diabetes mellitus) • Moderate or severe acute illness with or without fever

1. When a contraindication is present, a vaccine should **NOT** be administered. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization.
2. When a precaution is present, vaccination should generally be deferred but might be indicated if the benefit of protection from the vaccine outweighs the risk for an adverse reaction. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization.
3. Vaccination providers should check FDA-approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. See Package inserts for U.S.-licensed vaccines.

Appendix

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

Vaccines and other Immunizing Agents	Contraindicated or Not Recommended[1]	Precautions[2]
Dengue (DEN4CYD)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Lack of laboratory confirmation of a previous dengue infection	• Pregnancy • HIV infection without evidence of severe immunosuppression • Moderate or severe acute illness with or without fever
Diphtheria, tetanus, pertussis (DTaP)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within 7 days of administration of previous dose of DTP or DTaP	• Guillain-Barré syndrome (GBS) within 6 weeks after previous dose of tetanus-toxoid–containing vaccine • History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid–containing or tetanus-toxoid–containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid-containing vaccine • For DTaP only: Progressive neurologic disorder, including infantile spasms, uncontrolled epilepsy, progressive encephalopathy; defer DTaP until neurologic status clarified and stabilized • Moderate or severe acute illness with or without fever
Haemophilus influenzae type b (Hib)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Younger than age 6 weeks	• Moderate or severe acute illness with or without fever
Hepatitis A (HepA)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including neomycin	• Moderate or severe acute illness with or without fever
Hepatitis B (HepB)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including yeast • Pregnancy: PreHevbrio is not recommended due to lack of safety data in pregnant women. Use other hepatitis B vaccines if HepB is indicated[4]	• Moderate or severe acute illness with or without fever
Hepatitis A-Hepatitis B vaccine (HepA-HepB) [Twinrix]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including neomycin and yeast	• Moderate or severe acute illness with or without fever
Human papillomavirus (HPV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • *Pregnancy: HPV vaccination not recommended.*	• Moderate or severe acute illness with or without fever
Measles, mumps, rubella (MMR) Measles, mumps, rubella, and varicella (MMRV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Pregnancy • Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent • For MMRV only: HIV infection of any severity and children younger than age 4 years	• Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) • History of thrombocytopenia or thrombocytopenic purpura • Need for tuberculin skin testing or interferon-gamma release assay (IGRA) testing • Moderate or severe acute illness with or without fever • For MMRV only: Personal or family (i.e., sibling or parent) history of seizures of any etiology • If using MMRV, see Varicella/MMRV for additional precautions
Meningococcal ACWY (MenACWY) MenACWY-CRM [Menveo] MenACWY-TT [MenQuadfi]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For Men ACWY-CRM only: severe allergic reaction to any diphtheria toxoid— or CRM197—containing vaccine • For MenACWY-TT only: severe allergic reaction to a tetanus toxoid-containing vaccine	• For MenACWY-CRM only: Preterm birth if younger than age 9 months • Moderate or severe acute illness with or without fever
Meningococcal B (MenB) MenB-4C [Bexsero] MenB-FHbp [Trumenba]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Pregnancy • For MenB-4C only: Latex sensitivity • Moderate or severe acute illness with or without fever
Meningococcal ABCWY (MenACWY-TT/MenB-FHbp) [Penbraya]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe allergic reaction to a tetanus toxoid-containing vaccine	• Moderate or severe acute illness, with or without fever
Mpox [Jynneos]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Moderate or severe acute illness, with or without fever
Pneumococcal conjugate (PCV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe allergic reaction (e.g., anaphylaxis) to any diphtheria-toxoid-containing vaccine or its component[3]	• Moderate or severe acute illness with or without fever
Pneumococcal polysaccharide (PPSV23)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Moderate or severe acute illness with or without fever
Poliovirus vaccine, inactivated (IPV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Pregnancy • Moderate or severe acute illness with or without fever
RSV monoclonal antibody (RSV-mAb)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[5]	• Moderate or severe acute illness with or without fever
Respiratory syncytial virus vaccine (RSV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Moderate or severe acute illness with or without fever
Rotavirus (RV) RV1 [Rotarix] RV5 [RotaTeq]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe combined immunodeficiency (SCID) • History of intussusception	• Altered immunocompetence other than SCID • Chronic gastrointestinal disease • RV1 only: Spina bifida or bladder exstrophy • Moderate or severe acute illness with or without fever
Tetanus, diphtheria, and acellular pertussis (Tdap) Tetanus, diphtheria (Td)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For Tdap only: Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within 7 days of administration of previous dose of DTP, DTaP, or Tdap	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of tetanus-toxoid–containing vaccine • History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid–containing or tetanus-toxoid–containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid–containing vaccine • For Tdap only: Progressive or unstable neurological disorder, uncontrolled seizures, or progressive encephalopathy until a treatment regimen has been established and the condition has stabilized • Moderate or severe acute illness with or without fever
Varicella (VAR) Measles, mumps, rubella, and varicella (MMRV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Pregnancy • Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent • For MMRV only: HIV infection of any severity and children younger than age 4 years	• Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) • Receipt of specific antiviral drugs (acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination (avoid use of these antiviral drugs for 14 days after vaccination) • Use of aspirin or aspirin-containing products • Moderate or severe acute illness with or without fever • If using MMRV, see MMR/MMRV for additional precautions

1. When a contraindication is present, a vaccine should NOT be administered. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.
2. When a precaution is present, vaccination should generally be deferred but might be indicated if the benefit of protection from the vaccine outweighs the risk for an adverse reaction. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.
3. Vaccination providers should check FDA-approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. Package inserts for U.S.-licensed vaccines are available at www.fda.gov/vaccines-blood-biologics/approved-products/vaccines-licensed-use-united-states.
4. For information on the pregnancy exposure registry for persons who were inadvertently vaccinated with PreHevbrio while pregnant, please visit www.prehevbrio.com/#safety.
5. Full prescribing information for BEYFORTUS (nirsevimab-alip) www.accessdata.fda.gov/drugsatfda_docs/label/2023/761328s000lbl.pdf.

Addendum

Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

In addition to the recommendations presented in the previous sections of this immunization schedule, ACIP has approved the following recommendations by majority vote since October 24, 2024.

Vaccines	Recommendations	Effective Date of Recommendation*
Meningococcal (MenACWYCRM/ MenB-4C, Penmenvy)	MenABCWY vaccine may be used when both MenACWY and MenB are indicated at the same visit in: 1. healthy persons aged 16–23 years (routine schedule) when shared clinical decision-making favors administration of MenB vaccine and 2. persons aged ≥10 years who are at increased risk for meningococcal disease (e.g., because of persistent complement deficiencies, complement inhibitor use, or functional or anatomic asplenia)	June 25, 2025
Influenza	ACIP reaffirms the recommendations for routine annual influenza vaccination of all persons aged ≥ 6 months who do not have contraindications for the 2025–2026 season	July 22, 2025
Influenza	ACIP recommends only single-dose formulations of annual influenza vaccines that are free of thimerosal as a preservative for three populations: - Children 18 years or younger - Pregnant women - All adults	July 22, 2025
RSV monoclonal antibody (Clesrovimab)	ACIP recommends infants aged < 8 months born during or entering their first RSV season who are not protected by maternal vaccination receive one dose of clesrovimab.	August 4, 2025
Note: As of May 29, 2025, the schedule incorporates the HHS directive regarding COVID-19 vaccine recommendations. (Changes were made to tables and notes for COVID-19 vaccines in pregnant women and children/adolescents ages 6 months through 17 years who are not moderately or severely immunocompromised).		

*The effective date is the date when the recommendation was adopted and became official.

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:

- 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);
- 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:

- It must be recommended by a licensed physician who is treating the enrollee or other licensed healthcare provider practicing within the scope of his or her license who is treating the enrollee; It must be required in order to diagnose or treat an enrollee's medical condition;
- It must be safe and effective;
- It must not be experimental or investigational; and
- 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 to 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 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 healthcare 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, then 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.

CHOICES Caregiver Assistance Services

CHOICES Caregiver Assistance Services

Service	How it can help you	Group 1	Group 2	Group 3	Limits
Adult Day Care	A place that provides supervised care and activities during the day.		✓	✓	2,080 hours per calendar year (January 1-December 31 each year)
In-Home Respite Care	Someone to stay with you in your home 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.)		✓	✓	216 hours per calendar year (January 1-December 31 each year)
Inpatient Respite Care	A short stay in a nursing home or assisted care living facility so your caregiver can have a break. (Only for routine family or other caregivers who aren't paid to support you.)		✓	✓	9 days per calendar year (January 1-December 31 each year)

Community Living Supports

Community Living Supports

Service	How it can help you	Group 1	Group 2	Group 3	Limits
Community Living Supports	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.		✓	✓	
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.		✓	✓	

CHOICES Community-Based Residential Alternatives

Choices community-based residential alternatives

Service	How it can help you	Group 1	Group 2	Group 3	Limits
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, this is available only for people who are ventilator dependent or who have traumatic brain injury. You must pay for your room and board.		✓		Limited to adults who are ventilator dependent or who have traumatic brain injury.
Companion Care	Someone you hire who lives with you in your home to help with personal care or homemaker services when you need it.		✓		Available only for Group 2 members in consumer direction who need care throughout the day and night that can't be provided by unpaid caregivers. And only when it costs less than other kinds of home care that would meet your needs.

CHOICES Hands-on Services

CHOICES Hands-on Services

Service	How it can help you	Group 1	Group 2	Group 3	Limits
Personal Care Visits	Someone to help you with personal care needs and support in the home, on the job, or in the community. If you need personal care, you can get help with household chores and errands too, but only for you (not other family members).		✓	✓	Visits up to 2,580 hours per calendar year.

CHOICES Additional Services

CHOICES Additional Services

Services	How it can help you	Group 1	Group 2	Group 3	Limits
Assistive Technology	Certain low-cost items or devices that help you do things easier or safer in your home like grabbers to reach things.		✓	✓	Up to $900 per calendar year (January 1-December 31 each year).
Minor Home Modification	Changes to your home that will help you get around more easily and safely like grab bars or a wheelchair ramp.		✓	✓	$6,000 per project; $10,000 per calendar year (January 1-December 31 each year); and $20,000 per lifetime (Not counted as part of overall service limit for CHOICES 3 members.)
Personal Emergency Response System	A call button you can use to get help in an emergency.		✓	✓	
Pest Control	Spraying your home to take care of an infestation such as for bugs or mice.		✓	✓	9 visits per calendar year (January 1-December 31 each year)
Home Delivered Meals	Nutritious meals that can be delivered fresh each day or frozen in bulk.		✓	✓	1 meal per day
Enabling Technology	Various forms of devices and technology to support		✓	✓	Up to $5,000 per calendar year and is

	independent living such as sensors, mobile applications, remote support systems and other smart devices.				available through March 31, 2025.

CHOICES Nursing Home Care

Choices Nursing Home Care

Services	How it can help you	Group 1	Group 2	Group 3	Limits
Nursing Home Care	A nursing home is a place that provides a room, meals, and help with activities of daily living. Most people in a nursing home have physical and/or mental health challenges that keep them from living on their own.	✓	✓ Short-term Only	✓ Short-term Only	For Group 2 and 3 members, limited to no more than 90 days, but only if the person is getting home care first, qualifies for nursing home care, and expects to only need a short stay,

Employment Supports- Individual Employment Supports

Employment Supports- Individual Employment

Service	How can it help you	Group 2	Group 3	Limits
Exploration – Individualized Integrated Employment	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

Service	How can it help you	Group 2	Group 3	Limits
Exploration – Self Employment	Helps you decide if you want to start your own business and the kind of business that would be right for you. Also helps you (and your family) understand the benefits of working and helps answer questions about work.	✓	✓	No more than once a year (at least 365 days between services)
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.

Service	How can it help you	Group 2	Group 3	Limits
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.
Job Development Start-Up or Self-Employment Start-Up	Someone to help you carry out your plan to get a job (or start your own business)	✓	✓	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.
Job Coaching	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.	✓	✓	Max 40 hrs. per week; 50 if employed at least 30 hours in individual integrated employment.
Job Coaching for Self-Employment	A job coach to support you when you start your business until you run the business by yourself	✓	✓	Max 40 hrs. per week; 50 if employed at least 30 hours in individual integrated self-employment.
Co-Worker Supports	Paying a co-worker to help you on your job instead of a job coach	✓	✓	Max 40 hrs. per week; 50 if employed at least 30 hours in individual integrated employment.
Career Advancement	Services to help you get a better job, earning more money	✓	✓	No more than once every 3 years to get a promotion or second job
Benefits Counseling	Someone to help you understand how the money you earn from working will impact other benefits you get, including Social Security and TennCare.	✓	✓	• 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,

Service	How can it help you	Group 2	Group 3	Limits
				promotion, or self-employment • Up to 8 extra hours 4 times a year to help you stay employed or self-employed

Employment Supports- Pre-Vocational Training

Pre-Vocational Training

Service	How it can help you	Group 2	Group 3	Limits
Integrated Employment Path Services	Time-limited trainings 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

Independent Community Living Supports

Independent Community Living Supports

Service	How it can help you	Group 2	Group 3	Limits
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. If you get it this service from a provider and aren't getting another service right before or after: • No more than 2 one-way trips per day • No more than 12 one-way trips per week for work • No more than 6 one-way trips per week to do integrated things in the community (besides work) • No more than 12 one-way trips per week **combined**

Employment and Community First CHOICES Benefit Table

Benefit Groups:

Group 4: Essential Family Supports

Group 5: Essential Supports for Employment and Independent Living

Group 6: Comprehensive Supports for Employment and Community Living

Group 7: Intensive Behavioral Family-Centered Treatment, Stabilization and Supports

Group 8: Intensive Behavioral Community Transition and Stabilization Services

ECF CHOICES Employment Supports

Individual Employment Supports

Service	How it can help you	Groups Covered	Limits
Exploration – Individualized Integrated Employment	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.	Groups 4, 5, 6, 7, and 8	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.
Exploration – Self Employment	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	Groups 4, 5, 6, 7, and 8	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.

Service	How it can help you	Groups Covered	Limits
	your questions about 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.	Groups 4, 5, 6, 7, and 8	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	Groups 4, 5, 6, 7, and 8	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)	Groups 4, 5, 6, 7, and 8	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 Start Up or Self-Employment Start Up	Someone to help you carry out your plan to get a job (or start your own business)	Groups 4, 5, 6, 7, and 8	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

Service	How it can help you	Groups Covered	Limits
Job Coaching	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.	Groups 4, 5, 6, 7, and 8	• Up to 40 hours per week of Job Coaching or Co-Worker Supports, Community Integration Support Services, Independent Living Skills Training, **AND** the hours you work **combined IF** 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 IF** you work in the community or you're self-employed in a community business at least 30 hours per week
Job Coaching for Self-Employment	A job coach to support you when you start your business until you run the business by yourself.	Groups 4, 5, 6, 7, and 8	• Up to 40 hours per week of Job Coaching or Co-Worker Supports, Community Integration Support Services, Independent Living Skills Training, **AND** the hours you work **combined IF** 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 IF** you work in the community or you're self-employed in a community business at least 30 hours per week
Co-Worker Supports	Paying a co-worker to help you on your job instead of a job coach.	Groups 4, 5, 6, 7, and 8	• Up to 40 hours per week of Job Coaching or Co-Worker Supports, Community Integration Support Services, Independent Living Skills Training, **AND** the hours you work **combined IF** 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 IF** you work in the community or you're self-employed in a community business at least 30 hours per week
Career Advancement	Services to help you get a better job, earning more money	Groups 4, 5, 6, 7, and 8	No more than once every 3 years to get a promotion or second job

Service	How it can help you	Groups Covered	Limits
Benefits Counseling	Someone to help you understand how the money you earn from working will impact other benefits you get, including Social Security and TennCare	Groups 4, 5, 6, 7, and 8	• 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 • Up to 8 extra hours 4 times a year to help you stay employed or self-employed

Small Group Employment Supports

Small Group Employment Supports

Service	How it can help you	Groups Covered	Limits
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	Groups 4, 5, 6, 7, and 8	Up to 30 hours per week of Supported Employment– Small Group, Community Integration Support Services, and Independent Living Skills Training combined

Prevocational Training

Pre-Vocational Training

Service	How it can help you	Groups Covered	Limits
Integrated Employment Path Services	Time-limited trainings to get you ready for work in the community	Groups 4, 5, 6, 7 and 8	• 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

Independent Community Living Supports

Independent Community Living Supports

Service	How it can help you	Groups Covered	Limits
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.	Groups 4, 5, 6, and 7	• 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* starting an Employment Informed Choice process • **If you do 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.	Groups 4, 5, 6, and 7	• 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* starting an Employment Informed Choice process • **If you do 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

Service	How it can help you	Groups Covered	Limits
			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
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.	Groups 4, 5, 6, and 7	Up to $225 per month if you to get this service through consumer direction If you get it this service from a provider and aren't getting another service right before or after: • No more than 2 one-way trips per day • No more than 12 one-way trips per week for work • No more than 6 one-way trips per week to do integrated things in the community (besides work) No more than 12 one-way trips per week **combined**
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	Groups 5 and 6	Up to 215 hours per month

Service	How it can help you	Groups Covered	Limits
	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.		
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.	Groups 4, 5, 6, 7 and 8	Up to $5,000 per calendar year (January 1 – December 31 each year)
Enabling Technology	Equipment and/or devices that support increased independence in your home, community, and/or workplace	Groups 4, 5, 6, 7 and 8	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.	Groups 4, 5, 6, 7 and 8	Up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime
Community Living Supports and Community Living	Support with activities of daily living and other tasks that help you live in the	Groups 5 and 6	

Service	How it can help you	Groups Covered	Limits
Supports–Family Model	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

Family Caregiving Supports

Services	How it can help you	Groups Covered	Limits
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.)	Groups 4, 5, and 6	Up to 30 days per calendar year or 216 hours per calendar year (January 1 – December 31 each year). **You have to pick one.** In Consumer Direction, you can **only** get hourly respite.
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	Group 4	

Services	How it can help you	Groups Covered	Limits
	with. This help could be in your home, on the job, or in the community. Includes help with your household chores (but not the whole family) 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 with your cleaning and laundry; help you fix and eat your meals. They can also support you in the community to do the things you want to do.		
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 Supportive Home Care). This payment helps offset lost wages or pays for things you need that aren't covered in ECF CHOICES. (But you must get the services you need to work and be part of your community.)	Group 4	• **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

Self-Advocacy Supports

Service	How it can help you	Groups Covered	Limits
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.	Groups 5, 6, and 8	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 Employment/Self - Employment and Independent 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) • Think about and try employment or community living options.	Groups 5, 6, and 8	Up to $1,500 per lifetime
Decision Making Supports	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 fees for these options but you have to get the counseling service first.	Groups 4, 5, 6, 7, and 8	• Up to $500 per lifetime • Must get counseling service first

Family Empowerment Supports

Family Empowerment Supports

Service	How it can help you	Groups Covered	Limits
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	Groups 4 and 7	

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.	Groups 4 and 7	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.	Groups 4 and 7	
Health Insurance Counseling/ Forms Assistance	Training and support to help you understand and use your insurance benefits (including TennCare, Medicare and private insurance).	Groups 4 and 7	Up to 15 hours per calendar year (January 1 – December 31 each year)

Dental Services

ECF CHOICES Dental Services

Service	How it can help you	Groups Covered	Limits
Adult Dental Services	Dental care for adults age 21 and older, including services such as dental exams, cleanings, fillings, crowns, root canals, and dentures. (Children under age 21 already have dental care through TennCare.)	Groups 4, 5, 6, and 8	• 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

Therapy Supports

Therapy Supports

Services	How can it help you	Groups Covered	Limits
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	Groups 5, 6, and 8	• 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

Intensive Behavioral Supports

Intensive Behavioral Supports

Service	How it can help you	Groups Covered	Limits
Intensive Behavioral Family Centered Treatment, Stabilization and Supports (IBFCTSS)	Combines mental health treatment and other home-based supports in a family-centered way. Provided only for a limited number of children who live with their family and have challenging behavior support needs. The services will train and support your family to support you so you can keep living safely together.	Group 7	
Intensive Behavioral Community Transition and Stabilization Services (IBCTSS)	Combines short-term 24/7 residential services with mental health treatment and supports for a limited number of adults with severe behavior support needs. The services will help you	Group 8	

Service	How it can help you	Groups Covered	Limits
	transition safely to the community.		

Katie Beckett Benefit Table

Katie Beckett Benefit Table

Service	How it can help you	Katie Beckett Part A	Medicaid Diversion Part B	Continued Eligibility Part C	Limits
Medicaid Benefits for Children, Including Early Periodic Screening, Diagnosis, and Treatment Services	All of the physical and behavioral health care Medicaid must cover for children, including doctor visits, hospital care, therapies, nursing, home health care, medical equipment and supplies, and dental, vision, and pharmacy services	✓		✓	
Assistance with Premium Payments	Help paying the child's cost only of private health insurance	✓ **Only for hardship**	✓		
Automated Health Care and Related Expense Reimbursement	A debit card to pay for things the Internal Revenue Service (IRS) says are medical expenses—like doctor, hospital and pharmacy co-pays		✓		
Individualized Therapeutic Support Reimbursement	Getting paid back for approved care your child needs for their disability (even though the IRS wouldn't count it as a medical expense)		✓		
Respite	Someone to support your child for a short time so you can have a break. (**Only** for routine family or other caregivers who aren't paid to support your child.) You can hire your child's respite caregivers—called Consumer Direction. Or, you can choose a	✓	✓		Up to 30 days per calendar year or 216 hours per calendar year (January 1 – December

Service	How it can help you	Katie Beckett Part A	Medicaid Diversion Part B	Continued Eligibility Part C	Limits
	provider agency to give your child's respite in your home.				31 each year). **You have to pick one.** You can **only** get hourly respite in Consumer Direction.
Supportive Home Care	Someone to help with your child's personal care needs or daily living activities in your home or in the community (but not at school). You can hire your child's caregivers—called Consumer Direction. Or you can choose a provider agency to give your child's care in your home.	✓	✓		
Assistive Technology, Adaptive Equipment and Supplies	Certain items that help your child 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 your child 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
Vehicle Modifications	Certain changes to your vehicle that will help you transport your child easier	✓	✓		Up to $10,000 per calendar

Service	How it can help you	Katie Beckett Part A	Medicaid Diversion Part B	Continued Eligibility Part C	Limits
	and safer				year and $20,000 per lifetime
Community Integration Support Services	Helps your child do things in the community that your child wants to do. Take a class, join a club, volunteer, get or stay healthy, do something fun, build relationships, and reach your child's goals	✓	✓		Up to 20 hours per week
Community Transportation	Helps your child get to places in the community if you or someone else can't take them. In Consumer Direction, this can be used to pay someone back for gas, for bus fare, a taxi service, etc. Or you can choose a provider to help transport your child. (This is not for medical appointments. But for children in Part A and Part C, TennCare covers those too— called Non-Emergency Medical Transportation.)	✓	✓		Up to $225 per month if you to get this service through consumer direction
Decision Making Supports	Help understanding options to protect the rights and freedom of children with disabilities as they become adults, while providing the support they need to make decisions. Can include help paying for legal fees for these options but you have to get the counseling service first.	✓	✓		Up to $500 per lifetime Must get counseling service first

Service	How it can help you	Katie Beckett Part A	Medicaid Diversion Part B	Continued Eligibility Part C	Limits
Family Caregiver Education and Training	Help paying for workshops and training that will help family caregivers understand, support and advocate for your child and help your child advocate for him/herself	✓	✓		Up to $500 per calendar year (January 1 – December 31 each year)
Family-to- Family Support	Guidance and support from another parent of a child with disabilities who has experience and training	✓	✓		
Community Support Development, Organization, and Navigation	Helps your child and other with disabilities and their families: - Connect with and help each other, and - Find and use resources inyour community	✓	✓		
Health Insurance Counseling/ Forms Assistance	Training and support to help you understand and use your child's insurance benefits (including TennCare, Medicare and private insurance)	✓	✓		Up to 15 hours per calendar year (January 1 – December 31 each year)

Do you need help? We have free auxiliary aids and services, like large print, to communicate effectively with you. Call us at 1-800-468-9698 (TRS: 711) If you speak a language other than English, help in your language is available for free. We have free interpretation and translation services to help you.

Spanish: Español ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-468-9698 (TRS/TTY: 711: 1-866-503-0264).

Arabic: العربية

ملاحظة: إذا تتكلم اللغة العربية، خدمات المساعدة اللغوية متوفرة لك مجانًا. اتصل برقم: 1-800-468-9698 (TRS/TTY: 711 أو 1-866-503-0264)

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1-800-468-9698 (TRS/TTY: 711: 1-866-503-0264)

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 1-800-468-9698 (TRS/TTY: 711: 1-866-503-0264).

Korean: 한국어 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-468-9698 (TRS/TTY: 711: 1-866-503-0264) 번으로 전화해 주십시오.

French: Français ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-468-9698 (ATS: 711: 1-866-503-0264).

Amharic: አማርኛ ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-468-9698 (TRS/TTY: 711: 1-866-503-0264).

Gujarati: ગુજરાતી સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-468-9698 (TRS/TTY: 711: 1-866-503-0264).

Laotian: ພາສາລາວ ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-468-9698 (TRS/TTY: 711: 1-866-503-0264).

German: Deutsch ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-468-9698 (TRS/TTY: 711: 1-866-503-0264).

Tagalog: Tagalog PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-468-9698 (TRS/TTY: 711: 1-866-503-0264).

Hindi: हिंदी ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-468-9698 (TRS/TTY: 711: 1-866-503-0264) पर कॉल करें।

Russian: Русский ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-468-9698 (TRS/TTY: 711: 1-866-503-0264).

Japanese: 日本語 「日本語を話す方は、 通訳や翻訳などの言語支援サービスを無料で利用できます」 電話1-800-468-9698 (TRS/TTY: 711: 1-866-503-0264).

Persian: فارسی

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-468-9698 (TRS/TTY: 711: 1-866-503-0264) تماس بگیرید.

The Beneficiary Support System (BSS) helps people who are enrolled in the CHOICES, Employment and Community First (ECF) CHOICES, and the Katie Beckett program. They also help people who want to enroll into these programs. For help call 1-888-723-8193.

The TennCare Program does not discriminate against people because of their race, color, national origin including limited English proficiency and primary language, age, disability, religion, or sex. If you need reasonable modifications or think you were treated differently, or discriminated against you can file a grievance (complaint) with TennCare's Office of Civil Rights Compliance at HCFA.fairtreatment@tn.gov, https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html, 310 Great Circle Road Floor 3W, Nashville, TN 37243, or calling (TRS/TTY: 711: (615) 507-6474. Need help filing a grievance? Call TennCare Connect at 1-855-259-0701.

Notes

Notes

Do you need help with your health care, talking with us, or reading what we send you? If so, call us for free at:
BlueCare **1-800-468-9698**
TennCare*Select* **1-800-263-5479**
CoverKids **1-888-325-8386**
(TRS: **711** ask for **888-418-0008**)

BlueCare Tennessee

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1 Cameron Hill Circle | Chattanooga, TN 37402 | **bluecare.bcbst.com**

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