


VHP *COMMUNITYCARE*

**Member Handbook
&
Explanation of Coverage**

IMPORTANT PHONE NUMBERS

VHP Member Services/Eligibility? ? ? ? ? ? ? ? ? ? . (615) 782-7878
TTY..... (800) 848-0298
Non-English Speaking Line..... (615) 782-7848
(You will be assisted by an interpreter)
Mental Health Services/Substance Abuse (Premier)... (800) 325-7864
Pharmacy Services? ? ? ? ? ? ? ? ? ? ? ? ? ? ? ? ? ? (800) 527-4514
Transportation Services? ? ? ? ? ? ? ? ? ? ? ? ? ? ? ? .. (615) 862-6630
(for non-emergency care)
Website www.vhptn.com

Your Primary Care Provider:

Name: _____
Address: _____
Telephone: _____

TennCare Bureau Hotline? ? ? ? ? ? ? ? ? ? ? ? ? ? ? ? ? ? (800) 669-1851

IMPORTANT ADDRESSES

VHP Administrative Office:
*VHP CommunityCare
215 Centerview Drive, Suite 300
Brentwood, TN 37207*

VHP Claims:
*VHP CommunityCare
P.O. Box 472007
Tulsa, OK 74147*

This booklet contains only a general description of the benefits available to you under VHP. The benefits are subject to all terms, conditions, limitations and definitions in the contract as well as all provisions required by state laws.

Your VHP Facts and Information



Fill this out now and update it whenever you have changes.

	NAME	VHP IDENTIFICATION NUMBER	PRIMARY CARE PROVIDER (PCP)	PRIMARY CARE PROVIDER (PCP) PHONE NUMBER
SELF				
SPOUSE				
CHILD				
CHILD				
CHILD				
CHILD				
CHILD				
CHILD				
CHILD				
CHILD				
CHILD				
CHILD				

Covered Preventive Health Services for Non-pregnant Adults:

Age ? Service ?	Initial Visit Ages 19 & above	Follow-up Visits Ages 19-39 years	Follow-up Visits Ages 40-64 years	Follow-up Ages 65 & Up
History & Physical	Once – initial vists	Every 1-3 years	Every 1-3 years	Every year; also Hearing and Visual Acuity
Laboratory	As indicated for evaluation	Pap smear every 1-3 years, Total cholesterol; Others if special risk, for example, Mammography (check with PCM)	Pap smear every 1-3 years; Mammography every 1-2 years after age 50; Total Cholesterol; Other for members with special risk factors (check with your PCP for additional lab studies)	Mammography every 1- 2 years until age 75 (women); Thyroid indices (women); Dipstick Urinalysis; Total Cholesterol; Members with special risk factors (check with your PCP for additional lab studies such as Pap smear)
Special Counseling	Health Habits; lifestyle issues; injury Prevention; Nutrition; etc. (check with your PCP)	Injury prevention; Dental Health; Hemoglobin Testing and Skin Protection from Ultraviolet Light (for members with special risk factors)	Injury prevention; Dental Health; Skin Protection from Ultraviolet Light; Discussion of aspirin therapy in men and estrogen replacement in women	As for 40-64 years; Also glaucoma testing
Immunizations	Tetanus – Diphtheria booster every 10 years or as indicated	Tetanus – diphtheria booster every 10 years; Members with special risk factors: Hepatitis B, Pneumococcal; Influenza (every year); Measles, Mumps, Rubella	As for 19-39 years, excluding measles – mumps & rubella (MMR)	Tetanus-diphtheria booster every 10 years; Influenza every year; Pneumoccal and as needed, Hepatitis B



Member Handbook



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Introduction

What is TennCare?

TennCare is the name of the State of Tennessee's health plan. TennCare covers Medicaid enrollees and some uninsured and uninsurable people. TennCare guidelines are from the Bureau of TennCare, an agency of the State of Tennessee, Department of Health. The Bureau of TennCare works with many managed care organizations (MCOs) in Tennessee like VHP.

What is VHP?

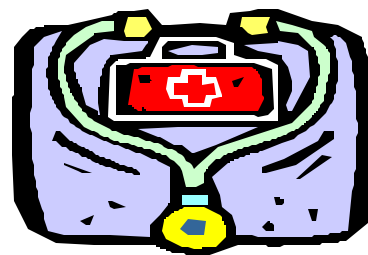
VHP is a Health Maintenance Organization (HMO). It covers you for preventive health care (breast exams, immunizations for children, periodic checkups, etc.) as well as other care usually covered by traditional insurance. VHP wants to provide care in the most appropriate, cost effective setting. VHP uses a primary care provider – also called a PCP – to coordinate and manage your care. VHP's network of health care providers includes Vanderbilt University Medical Center and approximately 450 primary care and specialty doctors and nurse practitioners. This network and VHP work together to help you stay healthy and to find health problems early.

Welcome to VHP

This is your VHP Member Handbook. It tells you how to use VHP. Keep this book where you can find it easily. If you have questions about anything in this book, call VHP Member Services, Monday – Friday, 8am-5pm at (615) 782-7878. We welcome your calls and questions.

Assurance of Non-discrimination

No person on the grounds of race, color, national origin, sex, age or disability shall be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or service provided by VHP.



How You Become Eligible

Eligibility

Eligibility and enrollment of TennCare members is determined by the TennCare Bureau. Eligibility in VHP is limited to people who meet the following criteria:

- ? are eligible for Medicaid or for both Medicare and Medicaid under the Tennessee Medicaid program
- ? are unable to buy health insurance because of an existing medical condition
- ? do not have access (either directly or through a family member) to employer-sponsored health insurance or another government health plan, and who continue to lack access
- ? children under age 19 who do not have access to insurance through their parent's employment
- ? reside in the community service area(s) in which VHP is authorized to serve

Changing Plans

You may change to another MCO:

- ? during the first 45 days after you get a letter from TennCare telling you which MCO you are in
- ? during a yearly period of open enrollment
- ? if you move out of VHP's service area
- ? any time you are dissatisfied, and TennCare says you can change plans (you must go through the appeal procedure)

Disenrollment from VHP

The only reasons you can be removed from the VHP plan are if you:

1. change your managed care organization (MCO) during the next MCO change period or within 45 days after you first enroll;
2. no longer qualify for TennCare eligibility;
3. you become eligible to participate in an employer sponsored plan or medicare;
4. you purchase individual non-employer health coverage;
5. disenroll on your own from TennCare (call the Bureau of TennCare at 1-800-669-1851 to find out how);
6. are able to pay your premiums but fail or refuse to pay them (there is a sixty (60) day grace period before TennCare begins disenrollment);
7. are able to pay your VHP deductibles and copayments, but do not do so, and TennCare approves the disenrollment;
8. move outside of the VHP service area;
9. let someone else use your VHP ID card to get health care services;
10. willfully and repeatedly refuse to comply with VHP's requirements or TennCare's requirements;

11. use your VHP ID card to seek drugs or supplies illegally or for resale; or
12. obtain TennCare eligibility by fraud, misrepresentation, deception, or your existence, identity, and/or eligibility can not be verified;
13. fail to reply to requests for verification of the information you provided on your TennCare application, or information the Bureau of TennCare gets from the reverification process, another TennCare member, provider, or VHP at any time;
14. cannot be located by the Bureau of TennCare; or
15. if you die.

If VHP decides to ask the Bureau of TennCare to remove you from our plan, the Bureau of TennCare will let you know. The Bureau will decide whether you should be removed, tell you the reason for your removal and give you a chance to appeal.



You and Your Primary Care Provider

Going to Your Primary Care Provider for Your Health Care

With VHP, you have a Primary Care Provider, or PCP. Your PCP is your doctor, nurse practitioner or physician assistant you go to for your health care. Each VHP member has a Primary Care Provider. Your PCP's name is listed on the front of your VHP ID card.

Your PCP can give you vaccines, tests and tips on health, diet and exercise. Most of your health care will come from your PCP. Regular visits to your PCP will help keep you healthy.

Your PCP will have your medical records. This helps your PCP keep track of any care you have had, and see your whole health care picture.

Your primary care provider will give you care, or when needed, send you to a specialist for care. When your PCP sends you to a specialist for care, it is called a referral. See page 14 for more information about specialist care.

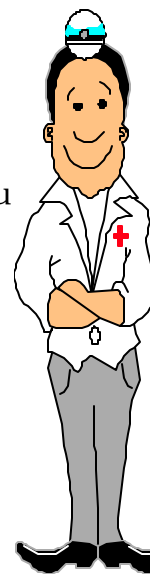
REMEMBER: Your PCP must okay your health care, or VHP may not pay the cost of the care (unless it is an emergency).

If you also have Medicare, see the section for Medicare on page 24 for special Medicare instructions. If you have Medicare and TennCare, you can keep seeing your Medicare doctor, **unless** your Medicare plan is Part A (Hospital Care Only). If you have Medicare Part A, you need to see your VHP PCP for your care. If you have Medicare, you need to get your medicine from a drug store that works with VHP.

How to Get Health Care with Your Primary Care Provider

Make an appointment to meet your PCP as soon as you can. This is important if you were getting regular care or treatment before you became a VHP member or if you change to a new PCP. The name of your PCP is on the front of your VHP ID card. Your PCP's name, address, phone number and office hours are in your VHP Provider Directory. When you are ready to see your PCP;

- ? call your PCP's office for an appointment
- ? have your VHP ID card ready when you call.
- ? say you are a VHP member and give your VHP ID number (Social Security number),
- ? write down your appointment date and time and any other instructions,
- ? be on time for your appointment;
- ? have your VHP ID card with you when you go,
- ? pay any copay or deductible you may need to pay, and remember,
- ? if you cannot keep your appointment, call the PCP's office to get a new time set.



If you need help getting to your VHP appointment, you may be able to get a driver or van to take you. VHP can help you with this through your local Community Service Agency. See page 19 for more information on transportation services. You should see your PCP for regular checkups, even if you feel OK. Care

that keeps you healthy is sometimes called **wellness** or **preventive care**. This care may be vaccines, tests or well child care. **No VHP member ever has to pay a copayment or deductible for covered preventive services.**

Getting to Know Your Primary Care Provider (PCP)

When you first meet your PCP, bring any medicine you are taking. This will help your PCP know what health care you have been getting. Asking questions about your health and your health care will help you and your PCP get to know each other. Some questions you might ask are:

- ? How is my health?
- ? What should I do to stay healthy?
- ? What tests should I have and when? Why?
 - Regular checkups?
 - Mammogram (breast exam)?
 - Blood pressure checks?
 - Prostate exam?
 - Cholesterol checks?
 - Well-child visit?
 - Pap smear?
 - Dental exam?
- ? What do the tests I have taken mean?
- ? When should I have vaccines?

How often should I see you?
Answers for adults and children may be different. It is a good idea to write this information down when you see your PCP.

If your PCP decides not to work with VHP any more, we will send you a letter telling you this and a new VHP ID card to use with a new PCP's name on it. You can see the

PCP listed on the new ID card, or you can choose a new PCP.

To choose a new PCP, just look in your VHP Directory for a PCP near you. Call the PCP's office to make sure that the PCP is still working with VHP and to find out if he or she is taking new patients. Call VHP Member Services to let us know your PCP choice

How to Get Care When You Feel Sick, At Home or Away

You may not know if you need health care. If you are unsure, call your Primary Care Provider's (PCP's) office during regular business hours for help. PCPs provide 24-hour coverage for all patients. If you call your PCP's office after it is closed, you should be able to talk to the answering service to find out if your PCP is on-call or if your PCP has another health caregiver seeing patients for him or her. Services will be covered as stated in your Explanation of Coverage (found in the back of this Handbook).



If you are away from home when you feel sick, follow the same steps. Your PCP may tell you to get care before you return home. When you get your care, show your VHP ID card and ask the caregiver to send the bill to VHP. If the caregiver will not send the bill to VHP, ask if they will send the bill to you at home. When you get the bill, call the VHP Member Services telephone number for help. (615-782-7878) If you have

to pay for the health care services when you get the care, make sure you get a bill from the health caregiver before you return home. When you return home, call VHP Member Services and tell them about your bill.

Remember to show your VHP ID card when you get care.

When you call your PCP, you may be asked some of these questions to help find out what care is needed:

- ? What is wrong (why you are calling)?
- ? How long have you felt sick?
- ? What have you done to feel better?
- ? What has made you feel better or worse?
- ? What is your child's age and weight (if the call is for your child)?
- ? What VHP drug store do you use (have the name and telephone number handy)?



How to Get Specialist Care

Your Primary Care Provider needs to see you for your health care. He or she will know what care is best for you. Your Primary Care Provider will either give you the care or send you to a specialist for care.

If your PCP wants you to go to a specialist for care, it is called a referral.

- ? Be on time for your appointment. Have your

VHP ID card with you when you go.

- ? Pay any copay or deductible you may need to pay. If you cannot keep your appointment, call your PCP's office to get a new time set.

Remember: Please have your PCP okay all of your care, unless it is an emergency.

How to Get Hospital Care

Your PCP or Specialist will know your health and is the best person to decide where you should get care. If you need hospital care, your PCP or Specialist will set it up for you, as well as lab and pre-admission testing. If it is needed, your PCP or Specialist can also help you get care at home once you have left the hospital.

Be sure to show your VHP ID card to the hospital so it will have the necessary identification and phone numbers.

Referrals Received Prior to Enrolling in VHP

You may have referrals or authorizations from another TennCare plan that you have not used, or prescriptions you have not filled, before you join VHP. **They are not valid on and after the effective date of your VHP membership.** You should make an appointment with your VHP PCP to get referrals, authorizations and/or prescriptions within the VHP network.

Preventive Services

VHP covers preventive care for adults and children. That means care to keep you well and to catch health problems early.

YOU DO NOT PAY ANY COPAYMENT FOR COVERED PREVENTIVE CARE.

Here is a list of some kinds of preventive care services that are covered when you go to your doctor for a preventive check-up:

- ? regular check-ups for adults and children
- ? care for women expecting a baby
- ? well baby care
- ? shots for adults-tetanus, diphtheria, hepatitis B, pneumonia, flu, measles, mumps, and TB;
- ? tests for cholesterol, blood sugar, colon and rectal cancer, bone hardness, thyroid tests, test for diseases you get from having sex, tests for HIV and AIDS, pap smears, mammograms for breast cancer, urine tests, EKG tests for heart problems, tests for hearing, and for PPD
- ? birth control information
- ? EPSDT for children under 21

EPSDT Services

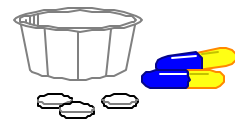
Under EPSDT (Early Periodic Screening, Diagnosis and Treatment) for children under 21 we cover:

- ? 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 mental problems. This is called “screening” and needs to happen according to a regular schedule.

For example, children from birth through age 2 are entitled to eleven “screens”; from age 3 through 11 seven “screens” and from age 12 through 20, nine “screens”. In addition, a child is entitled to a “screening” whenever the child is referred to a doctor by someone such as a teacher who notices a change which might require a screening; and

- ? treatment, including rehabilitation, for any health problems (physical, mental or developmental) discovered during a “screening”; and
- ? regular visits to a dentist for checkups and treatment; and
- ? immunizations (shots) for diphtheria, tetanus, pertussis, polio, measles, mumps and HIB flu, and
- ? lab tests for lead in blood and sickle cell anemia if the child is in a situation that might put
- ? him or her at risk for either or both.

Special Needs



Where to Go for Your Medicine

If you need medicine, you need to go to a pharmacy or drug store that works with VHP to get your VHP covered prescriptions, unless it is an emergency.

For help finding a VHP pharmacy or drug store near you, look in the VHP Provider Directory in the back of this book or call VHP Member

Services at 615-782-7878. Make sure you show your VHP ID card to the pharmacist when you get your covered prescription filled.

VHP has a list of drugs they cover. Your PCP or other health caregiver will have this list. If the drug your PCP or other health caregiver prescribes is not on the list, and your pharmacist says VHP will not cover your medicine, ask the pharmacist to call your PCP or other health caregiver who wrote the prescription. He or she may okay a different drug that is on the list. Some drugs are not covered by TennCare and VHP will not pay the cost of these drugs. Some examples of drugs not covered are ones used for cosmetic reasons, like Rogaine and drugs used for treating impotence, like Caverjet and MUSE.

If...

- ? your PCP or other health caregiver cannot get the medication approved on the day he or she asks for it, or the pharmacist cannot reach your PCP or other health caregiver to tell him or her the drug is not on the VHP list, the pharmacy must give you a 72-hour supply of the drug or up to the amount prescribed if less than a 72-hour supply as long as the drug:
 - ? is classified by the Food and Drug Administration as being effective,
 - ? is a covered therapeutic drug by TennCare,

- ? will not cause a bad reaction to your medical condition,
- ? will not go against any state or federal controlled substance laws.

If...

- ? the medication your PCP or other health caregiver prescribes does not get okayed by VHP, you may need to pay for the medicine yourself.

If...

- ? you have a copayment for your prescription drugs, you need to pay it.

If...

- ? you also have Medicare, you need to go to a pharmacy or drug store that works with VHP to have your TennCare covered medicine paid for.

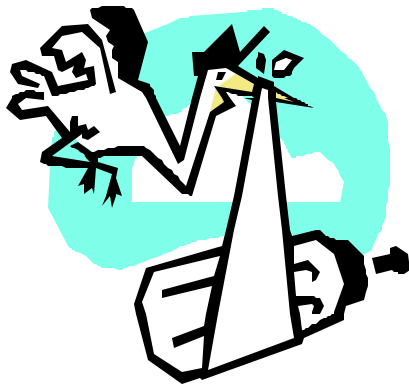


Mental Health and Drug or Alcohol Abuse Care

There may be a time when you need care for mental health or drug or alcohol abuse. All mental health or drug or alcohol abuse services are provided by TennCare Behavioral Health Organizations (BHOs). Certain BHOs work with certain TennCare health plans. If you change your TennCare plan, the BHO might also change. Your mental health drug and alcohol abuse services are managed

by Premier Behavioral Health Systems of Tennessee. You should have a separate member handbook and separate ID card from Premier for your mental health and drug and alcohol abuse care. Premier Behavioral Health Systems of Tennessee can be reached anytime at 1-800-325-7864.

You do not have to see your Primary Care Provider before getting help for mental health or drug or alcohol abuse.



Pregnancy and Childbirth

Regular health care before your baby is born will help you have a safer delivery and healthier baby. If you are pregnant, you can go to your PCP, or a obstetrician/gynecologist. You do not need an okay (a referral) from your PCP to see an obstetrician/gynecologist. If you are not sure if the obstetrician/gynecologist works with VHP, call his or her office or VHP Member Services to find out. If the obstetrician/gynecologist does not work with VHP, **VHP may not pay the cost of the care.**

Go to all of your appointments, even if you feel fine. And, it is important to take the vitamins you are given.

Once you have had your baby, you need to call your Primary Care Provider for follow-up care for yourself and your baby. **You also need to get your baby a TennCare identification number.** To help get this identification number call the TennCare Hotline toll free at 1-800-669-1851 or if you got Medicaid from the Department of Human Services (DHS), call your local office.

Doctors or Caregivers That Do not Usually Work with VHP (Out-of-Network Providers)

If your Primary Care Provider (PCP) needs to send you to a health provider who does not usually work with VHP, your PCP will get an okay from VHP first. **Except in an emergency, this is the only time VHP will pay the cost of a provider who does not work with VHP.**

If you currently pay a copayment for VHP coverage, you may need to pay the same amount to the health caregiver your PCP and VHP have okayed you to see. Not all VHP members are asked to pay copayments. **The front of your VHP ID card shows if you need to pay a copay.** If you have any problems getting an appointment with a VHP OB/GYN or your PCP, please call our Member Services department.

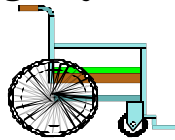
If you are pregnant at the time of enrollment, please call our Case Management department at 1-800-316-2273 ext. 3252.

If you develop medical problems during your pregnancy, you may be

assigned one of our VHP case managers to offer support and assistance in obtaining special healthcare services.

If you were seeing a healthcare provider before you were in VHP or you changed PCPs, your new VHP PCP should okay any care before you go to any other provider. You should tell your PCP about any care you were getting before you became a VHP member. Your PCP needs all of your health information to know what health care is best for you and which other providers you need to see.

Remember: If you go to a provider your PCP does not okay, VHP will not pay the cost of the care, unless it is an emergency.



Case Management

A case manager is a nurse or social worker who helps members with serious healthcare conditions or complicated healthcare needs get the medically necessary care when they need it. The case manager will:

- ? contact you for permission to assign you a case manager
- ? get information about your medical condition and anything that might affect it
- ? work with you to understand the kind of care you need
- ? work with you and your Primary Care Provider to help you get medically necessary care

- ? answer questions you might have about your health care services

You may be assigned a case manager to help organize your health care needs if:

- ? you visit the emergency room often
- ? you are admitted to the hospital often
- ? you need health care because of a transplant
- ? you have many medical needs from many different providers
- ? you are on numerous medications
- ? you need help finding medical care outside of a hospital setting

If you think you need case management services, call our Members Services Department at 615-782-7878. The member services representative will forward your information to the case management team. Your doctor or other healthcare provider may request case management services for you, but you will always be contacted by one of our case managers to get permission from you to assign you a case manager.

Healthcare can be very confusing especially during times of crisis. Your case manager is here to offer you support and guidance during this difficult time.



Disease Management

If you have to deal with a chronic condition (a condition that does not go away such as asthma or diabetes), you know how very important it is to control it on a daily basis. If you can control it,

then you will have a healthier, longer life. Disease Management nurses will support you and your health care providers in keeping you as healthy as possible by assisting with your education on the disease, by helping discover and remove anything that is stopping you from getting medically necessary care, medications on a regular basis. Our disease management team will be in contact with your healthcare providers. Remember it is very important that you follow your doctor's instructions on how to treat your condition.

We know it is very hard to deal everyday with a condition that is not going to go away. It is our hope that we can work with you and your healthcare providers to keep you as healthy as possible.

Transportation

If you cannot get to your VHP appointments, you may be able to get a taxi or van to take you. To find out if you are eligible for transportation services, call the Community Service Agency (CSA) at (615) 862-6630.

If you are able to use the transportation services, try to call your local CSA at least **one week before** your appointment, and have your VHP ID card with you when you get picked up for your appointment.

Note: If you choose a PCP more than thirty (30) miles or thirty (30) minutes away from your home even when another PCP's office is accepting new patients within thirty (30) miles or thirty (30) minutes of your home, VHP will not provide your transportation.



Emergencies



Emergency Health Care

If you think you have an emergency, go to the nearest emergency room or call 911, or your local ambulance service. If you are not sure if you need emergency care, call your Primary Care Provider's (PCP's) office. You do not need to get an OK from anyone before you get emergency care.

You can get emergency care 24 hours a day, seven days a week if you need it. These are some things that might be an emergency.

- ? shortness of breath, not being able to talk
- ? a bad cut, broken bone or burn
- ? bleeding that can not be stopped
- ? strong chest pain that does not go away
- ? strong stomach pain that does not go away
- ? seizures or "fits" that cause someone to pass out
- ? not being able to move your legs or arms
- ? a person who will not wake up from a drug overdose

These are some things that **usually** would **not** be an emergency.

- ? sore throat
- ? cold or flu
- ? ear ache
- ? small, not deep cuts
- ? headache, unless it is a very bad headache like you've never had before
- ? arthritis

An **Emergency Medical Condition** is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to pregnant women, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. Emergencies, as explained above, are covered both inside and outside the VHP service area.

Copayment for use the Emergency Room for Non-Emergency Care

If you use the emergency room when it is not an emergency, you may have to pay a copayment amount. This copayment amount is based on your income as follows:

<u>Proverty Level</u>	<u>Copayment Amounts for Non-Emergency Care</u>
0%-100%	\$0.00
101% - 199%	\$25.00
200% and above	%50.00

The amount of copayment you owe when you visit an emergency room for non-emergency care is shown on your ID card. If you go to a hospital emergency room and are admitted, you will not have to pay the emergency room copayment.

Members enrolled in the VHP Plan should receive their routine check-ups, immunizations, and preventive care from their PCP prior to taking trips or leaving the service area for any time. Please plan ahead when you know you will be out of the Plan's service area. Contact your PCP and discuss what routine care is needed and make sure you receive this care prior to leaving the service area.

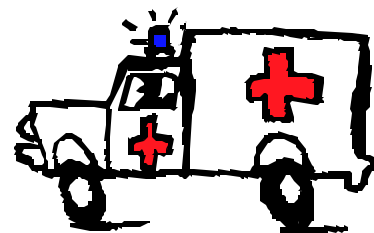
If you get emergency care, call or have someone call your PCP within 24 hours of the emergency care. Your PCP needs to know of any emergency care you get to help care for you after the emergency. If it is necessary for you to receive emergency care at a non-contracted facility; once your attending physician decides you are stable, you may be transferred to a contracted facility.

Out-of-Area Emergency Services

If you think you have an emergency when you are away from home, go to

the nearest emergency room or call 911 or the local ambulance service. If you get emergency care, call or have someone call your Primary Care Provider within 24 hours of the emergency care. Your PCP needs to know what has happened to help care for you after the emergency and when you get home.

If you get emergency care, show your VHP ID card at the time you get the emergency care. If you have to pay for the health care services when you get the care, make sure you get a bill from the health provider before you return home. When you return home, call Member Services and tell them about your bill. Ask that a claim form be sent to you. Once you get the claim form, fill in the information and attach a copy of the bill showing what you had to pay. Send the claim form and a copy of the bill to VHP to consider medical necessity for payment.



Teeth and Eyes



Care for Teeth

Children's teeth need special care. VHP members under 21 years can have a checkup and cleaning every six months. The American Academy of Pediatrics recommends that children start seeing a dentist by age 3 or even earlier for some children. In addition to checkups and cleanings, children are entitled to all medically necessary dental care they need.

Children do not have to see their PCP before seeing their VHP dentist. VHP dentists are listed in the VHP Provider Directory. Or you can call Member Services at 615-782-7878.

To make an appointment with a VHP dentist, call one near you and say the child is a VHP member. Give the child's name and VHP ID number. Be sure to give the child's VHP ID card to the office when getting care.

VHP does not pay for dental services for members **21 years and older** except for cases of accidental injury to or neoplasms of the oral cavity, life threatening infection, accidental injury to natural teeth including their replacement (limited to the cost of bridgework of the replacement of teeth injured in an accident unless teeth implants are medically necessary) and the removal of impacted wisdom teeth.

VHP members **21 years and older** need to see their PCP before getting any dental care. The PCP will work

with VHP when an adult needs to see a dentist. (The adult dental "accident" must be caused by some external force, like a car accident, not by some normal act of grinding of teeth while sleeping or any other naturally occurring circumstance.)

Adult members need to go to their PCP first and get an okay from VHP before getting dental care, or VHP will not pay the cost of the dental care. For a listing of dental services for members refer to your Explanation of Benefits (found in the back of this Handbook).



Care for Eyes

Children's eyes also need special care. VHP members 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, VHP will replace them as medically necessary. Your VHP eye doctor will show you which frames you can choose from. In addition to annual checkups and eyeglasses, children are entitled to all medically necessary treatments for their eyes that they need.

Children do not have to see their PCP before seeing their VHP eye doctor. VHP eye doctors are listed in the VHP Provider Directory. If you have trouble finding a VHP eye

doctor, call Member Services at 615-782-7878.

To make an appointment with a VHP eye doctor, call one near you and say the child is a VHP member. Give the child's name and VHP ID number. Be sure to take the child's VHP ID card to the office when getting care.

VHP will not pay for eyeglasses, contact lenses or examinations for prescribing or fitting them for members age **21 years and older** except for the first pair of cataract glasses or contact lens/lenses following cataract surgery.

Adult VHP members can get eye care when needed due to some illnesses or accidental injuries. **Adult VHP members age 21 years and older need to go to their PCP first to okay getting eye care or VHP will not pay for the cost of the care.**

If You Also Have Medicare

Special Medicare Instructions

If you have both Medicare and TennCare, you need to follow some special instructions with VHP.

If you Have Medicare Part A Only (Hospital Care Only)

1. You need to use a VHP Primary Care Provider (PCP) for your healthcare. Your PCP's name will be listed on the front of your VHP ID card.
2. You need to use a pharmacy or drug store that works with VHP for your VHP-covered medicine. These pharmacies or drug stores are listed in your VHP Provider Directory. Or, you can call the VHP Member Services Department for help finding one. Always show your VHP ID card when you have your VHP covered prescriptions filled.

If you Have Medicare Part B (Physician Care Only)

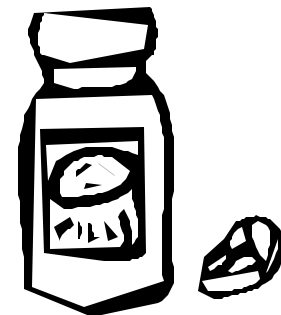
1. You **do not** have to use a Primary Care Provider (PCP) for all of your health care. You can keep using your Medicare doctor for health care services covered by Medicare. But if the health care services you get are not covered by Medicare, you need to go to a doctor who works with VHP **or VHP will not pay the cost of the care.**
2. If you choose to see a VHP Primary Care provider (PCP) for your health care, he or she

can help you on the road to health by:

- ? knowing about your health through regular checkups
 - ? giving you routine tests, vaccines, and health care advice; and
 - ? knowing any medicines you are taking, so they will work together.
3. You **do** need to use a pharmacy or drug store that works with VHP for your VHP covered medicine. Pharmacies or drug stores that work with VHP are listed in your VHP Provider Directory. Or you can call VHP Member Services. Always show your VHP ID card when you get VHP-covered prescriptions filled.

If You Have Medicare Part A and B (Hospital and Physician Care)

- ✍ Follow the same three rules for members who have Medicare Part B Only.



**Other Things You
Need To Know About
VHP**

Changing Your Name, Address, or Adding Family Members

Up-to-date information about you and your family will help you get important VHP information. If you change your name, address, or VHP eligible family members, write or call the Bureau of TennCare.

By mail, send changes to:
Bureau of TennCare
729 Church Street
Nashville, TN 37247-6501

By phone, call:
Bureau of TennCare
1-800-669-1851
Monday – Friday,
From 8:00am – 4:30pm
Central Standard Time
And, please call: VHP Member Services at 615-782-7878.
If you are Medicaid eligible, you also need to call your local Department of Human Services case worker.
If you are Social Security eligible, you also need to call your local Social Security office.

Changing Your Primary Care Provider (PCP)

You can change your PCP at any time. To change your PCP, call Member Services at 615-782-7878.

If you change your PCP on or before the 15th day of the month, you can start seeing your new PCP on the first day of the following month. For example, if you change your PCP on March 12, you can start seeing your new PCP on April 1.

If you change your PCP after the 15th day of the month, you can start seeing your new PCP the first day of the second month. For example, if

you change your PCP on March 20, you can start seeing your new PCP on August 1.

You should keep seeing your old PCP until your new PCP change take effect. If you do not remember when you changed your PCP, call Member Services to find out when you can start seeing your new PCP.

Whenever you change your Primary Care Provider (PCP), you will get a new VHP ID card with your new PCP's name on it. There will also be an effective date on your card that tells you when you can start seeing your new Primary Care Provider. Make sure to cut up and throw away your old VHP ID card after the effective date on your new VHP ID card.

If you are in the middle of a treatment plan when you change PCP's, call your new PCP right away to tell him or her about it. Your new PCP needs to know about any other care to make sure all of your care works together. If your new PCP wants you to stay with same treatment plan, he or she will give you a new referral.

Special note: If you change your PCP, any care that was already set up by your old PCP should be okayed with your new PCP.

Member Rights & Responsibilities

As a TennCare enrollee your responsibilities are:

- (1) To let TennCare know:
 - ? If you or a family member change your name, address, phone number, or if you have a change in family size.

- ? If you or a family member lose your job or change jobs.
- ? If you or a family member become employed.
- ? If you or a family member now have other health insurance for you.

Be sure to put the Social Security number for all family members who have TennCare (including yourself) on your letter. Mail it to TennCare at this address:

TennCare Member Services
 P. O. Box 22630
 Nashville, Tennessee 37202-2630

Or

By calling TennCare Monday – Friday from 8:00 a.m. to 4:30 p.m., Central Standard Time at:

741-4800, if you live in Davidson County or;

1-800-669-1851, if you live outside Davidson County, this is a free call or;

1-800-313-9240, if you have a hearing impairment, this is a free call.

If you or a family member became eligible for TennCare through the Department of Human Services (Medicaid) or the Social Security Administration YOU MUST call their local office in the county where you live and give them all of your information.

- (2) To pay your copayments and premiums that you are responsible for.

- (3) To make sure that you are the only who uses your TennCare identification card and let TennCare know if it is lost or stolen.
- (4) To show your TennCare identification card each time you have a doctor's appointment or you get medicine at a pharmacy. If you have any other health care insurance show your primary care manager the card for that too.
- (5) To go to your assigned primary care manager for all of your non-emergency medical care unless your primary care manager sends you to a specialist for care. If you are pregnant and do not wish to go to your primary care manager you may go to an obstetrician/gynecologist who works with your managed care organization.
- (6) To answer questions about your health that will help your primary care manager take care of you.
- (7) To always get your medicine from a pharmacy that works with your managed care organization unless it is an emergency.
- (8) To follow instructions given to you by your primary care manager.
- (9) To keep your scheduled health care appointments, be on time and call your primary care manger's office when you need to cancel an appointment.
- (10) To let your primary care manager know when you can not keep an appointment.

- (11) To let your primary care manager know when you have had to get medical care at an emergency room. It is your responsibility to do that, or have someone do it for you, within twenty-four (24) hours of emergency care.
- (12) To let TennCare know when you, or a family member, have a new baby. If you become eligible for TennCare through the Department of Human Services (Medicaid) or the Social Security Administration you must call their local office in the county where you live and tell them about the new baby.
- (13) To let us know if you have another insurance company that is going to pay for your medical care for any reason. Other insurance (health, auto, home, or worker's compensation, for example) must pay for medical care before TennCare pays.

New Law Passed

The Tennessee General Assembly has passed a new law. This law (Public Chapter 853) makes it a criminal act if anyone deliberately obtains TennCare coverage on false facts. It is also a violation of the law:

- ? For another person to help an individual obtain TennCare coverage based on false facts.
- ? To misrepresent, impersonate, or to conceal any fact that would cause TennCare to provide

coverage when a person is not other eligible.

- ? To get or help someone get additional benefits or benefits at a higher level than that for which they are entitled to receive.
- ? For any individual or business to make a false statement about a person's health status or eligibility for health insurance.

If found guilty, penalties range from re-paying TennCare and the MCO's for payments made for a person's health care to possible jail time. Health care providers can be banned from participating any further in the TennCare Program, as well as other penalties.

What You Have to Pay for Services

Depending on your income, you may have to pay. The amount you pay is called a copayment and is part of the bill every time you get medical services. If you use the emergency room when it is not an emergency, you may also pay a copayment. There is a limit on how much you have to pay in copayments each year. Once you reach that limit, the plan pays 100%. Your TennCare I.D. card will say how much your copayments are.

HOWEVER, NO ONE - NO MATTER WHAT HIS OR HER INCOME IS WILL HAVE TO PAY A COPAYMENT FOR PREVENTIVE SERVICES.

None of the doctors or other health care providers in our plan can refuse to give you medically necessary services because you fail to pay your copayments. But if you are able to pay and are simply

unwilling to pay them, we can ask TennCare to take you off our plan. This is called disenrollment.

Copayments

The following TennCare copayment schedule shall apply for both Uninsured and Uninsurable designations, based on the poverty level specified in TennCare rule 1200-13-12-05(1)(c):

Poverty Level	Copayment Amounts
0%-100%	\$0.00
101%-199%	\$5.00 Primary Care Provider and Community Mental Health Agency Services other than Preventive Care.
	\$15.00, Physician Specialists
	\$5.00, Prescription or Refill
	\$100.00, Inpatient Hospital Admission
	\$25.00, for hospital emergency room (waived if admitted)*
200% and Above	\$10.00, Primary Care Provider and Community Mental Health Agency Services other than Preventive Care.
	\$25.00, Physician Specialists
	\$10.00, Prescription or Refill
	\$200.00, Inpatient Hospital
	\$50.00, for hospital emergency room (waived if admitted)*

*If you go to a hospital emergency room and are admitted, you will **not** have to pay the emergency room copayment.

VHP Concerns

How to File a Complaint

If you are unhappy with your services and **it is not a medical problem**, you have a right to complain to us. If you have a problem with us, your doctor's office, your clinic, or your transportation services, call the VHP Member Services Department at 615-782-7878. We will do our best to solve your problem over the telephone. If your problem cannot be solved on the telephone, you can send us your complaint in writing. You have the right to get help with your complaint. You can use a family member, friend or lawyer to help you, if you wish. If you have a complaint about VHP, please let us know.

If you choose to put your complaint in writing, please send your complaint to:

VHP

**Attn: Member Services
Department
215 Centerview Drive, Suite 300
Brentwood, TN 37027**

We have to solve your problem within 30 days after you send us your complaint. We will tell you in writing what we decided and why.

If you need help with your complaint because of any kind of disability, call the TennCare hotline at 1-800-669-1851 (TTD 800-772-7647 for persons with hearing impairment). This is a free call. Tell the operator you need help with your complaint.

Your Rights to Appeal about Health Care Problems Under TennCare.

Para personas que hablan Espanol:
Para mas informacion llame al centro de informacion del Proyecto en espanol de TennCare al Tel: (615) 227-7568 si su llamada es en el condado de Davidson o condados que lo rodean, si es de larga distancia llame al Tel: 1-800-254-7568.

The TennCare Solutions Unit (TSU) can help you to get the health care you think you need. It can also answer your questions about your appeal rights. They can help you to start an appeal. You can call them at 1-800-878-3192, or you can write the TSU at P.O. Box 000593, Nashville, TN 37202-0593. Please call during the day if possible, but you may call anytime. If you have an emergency, someone can help you day or night.

If you need special help with an appeal because you have a health, learning, or other problem, please let us know. When you call the TSU at 1-800-878-3192 tell them about any help you need.

Do you have a speech or hearing problem and use a TTY machine to talk on the phone? There are operators to help you. A TTY machine will answer your phone call if you call 1-800-772-7647 or 313-9240 in the Nashville area. These

telephone numbers are to be used only by those with a TTY machine.

YOUR APPEAL RIGHTS

1. You have the right to appeal if you cannot get the health care you need when you need it. You can appeal even **if you do not have a doctor** to prescribe what you need. An appeal can help you get the care you need. You have 30 days to appeal. The 30 days start when you find out there is a problem.
2. If you appeal, someone else will take a look at what you need. They will try to fix it quickly. If they cannot, you will get a chance to tell your side of the story to someone who does not work for TennCare.
3. You have the right to get a letter from us if we (1) do not give you care, or (2) stop or cut your care, or (3) make you wait too long for medical care. This letter must say why we decided this and what you can do about it.
4. You have the right to get an answer when you need it. You need your TennCare health plan's **OK** ahead of time for certain types of care. If we take longer than 21 days to decide, we **MUST** give you the care you asked for. You can appeal before the end of the 21 days if the care you need cannot wait that long. Be sure to ask for a fast appeal.
5. You can get a fast appeal in some cases. You or your doctor must think the care is needed right

away. Tell TennCare why you need a fast appeal.

6. If you are already getting care, you may be able to keep getting it during the appeal. To do this, you must appeal by the date your care will be cut or stopped (usually 2 or 10 days). You must say that you want to keep getting the care during this appeal. **If you must have a doctor's order or prescription for the care, you can only keep getting the care if you have a doctor's order or prescription.** If the appeal is decided against you, you might have to repay TennCare for the cost of the care you got during the appeal.

7. In most cases, you have a right to get medicine even if the drug store says TennCare does not cover this drug. You may get a different drug that your doctor has OK'd. If not, you will get some of the drug your doctor ordered. **NOTE: You will not get the medicine if:**
It would not be safe for you, OR
It is a drug that does not work OR
It is a drug that is part of a group of drugs that TennCare does not cover for adults.

8. You may have the right to be told before we cut the care you are getting. If we decide to cut your care, you have the right to be warned in writing 10 days before it happens. If your **DOCTOR** wants to cut your medical care, you have the right to a two-day warning **IF:**

- (a) You are getting inpatient psychiatric or residential services, **OR**
- (b) Your TennCare health plan cannot get the care right away that you need next for your long-term health problem; **OR**
- (c) You are getting home health services.

If we do not tell you in time, we CANNOT cut your care.

8. You have the right to have TennCare pay your medical bills. Are you getting bills that TennCare should pay for? You must appeal within 30 days after you get the bill.

YOUR TENNCARE HEARING RIGHTS

You have the right to:

- (1) Have a hearing if your problem is not fixed.
- (2) Know about the hearing 3 weeks ahead of time (1 week for fast appeals).
- (3) Be at the hearing in person or by phone.
- (4) Speak for yourself at the hearing.
- (5) Have someone help you at the hearing.
- (6) See the information TennCare and your health plan used to decide about your care. You can see this before the hearing.
- (7) Look at your medical records and use them as proof.
- (8) Give the judge proof about your health and medical care.
- (9) Bring witnesses to testify for you.
- (10) Have the judge order your witnesses to come.

- (11) Question witnesses for TennCare.
- (12) Show proof that the health plan made the wrong decision.
- (13) Ask to have a doctor who does not work for TennCare say what medical care you need. You do not have to pay for this.
- (14) Get a written decision in 90 days (31 days if it was a fast appeal).
- (15) If the decision is late, you can get medical care until the decision is made. This is NOT true if you are the reason the decision is late.

In addition, you have the right to file an appeal for actions taken by VHP; you also have the right to request TennCare to review decisions related to your eligibility.

MAIL to TennCare Solutions, PO Box 00593, Nashville, TN 37202-0593 or
FAX: 1-888-345-5575 or **PHONE:** 1-800-878-3192
TTY/TDD: 1-800-772-7647 **ESPAÑOL:** 1-800-254-7568

TennCare Medical Care Appeal Form

Use this form only to appeal
Do NOT use it to apply for TennCare

1. Who is the TennCare patient?

Name _____ Social Security Number _____
Address _____ City _____ Zip Code _____
Birth Date _____ Daytime phone where you can be reached () _____
Doctor's Name _____ Doctor's Phone () _____

2. Who filled out this form? Patient Parent, relative, friend or advocate Doctor or medical staff

If not the patient, give name _____ Phone () _____

3. What is the care or medicine you are appealing about? _____

What is the problem with this care or medicine? Put checks in the blanks that apply

Can't get it _____ Getting only part of it _____ Had to pay for it _____ Getting bills for it _____
(Attach proof that you paid)

Change in care _____ Care cut or stopped _____ Ride is late or doesn't come _____ Too long a wait _____

Other (explain) _____

If you need more room, attach more paper.

Did you get a letter or paper explaining the problem? Yes _____ No _____ Date on letter or paper _____

Did your doctor prescribe the care or medicine you are appealing about? Yes _____ No _____

4. If you are appealing about a bill, when did you get it? _____

5. If you are appealing about medicine: What is the medicine? _____

Do you want TennCare to pay for this drug until your appeal is over (90 days)? Yes _____ No _____

(If your appeal is decided against you, you may have to repay TennCare for drugs after the 14-day supply.)

Did your doctor order this medicine? Yes _____ No _____ What doctor? _____

Did the drug store give you this medicine? Yes _____ No _____ Did TennCare pay for it? Yes _____ No _____

Which drug store did you go to? _____ Their Phone () _____

6. If you are appealing about care that is being changed, cut or stopped:

Do you want TennCare to pay for the same care until your appeal is over? Yes _____ No _____

(If your appeal is decided against you, you may have to pay later for care you got until the appeal was over.)

Does your doctor say you still need this care? Yes _____ No _____ What doctor? _____

Are you still getting the care now? Yes _____ No _____

7. Is a fast appeal needed because the care is needed right away? Yes _____ No _____

WHY is the care needed right away? _____

(If a doctor fills out this appeal, he/she must attach supporting information.)

8. If it is OK for TennCare to see your medical records, you or your authorized representative must sign here:

X _____ Date _____

How to fill out the TennCare Medical Care Appeal Form

The Member usually completes the TennCare Medical Care Appeal Form. However, if the Member requests your assistance, please complete the form based on the instructions below.

Section 1:

Print the full name of the person who is having trouble getting medical care. Be sure to fill in all the spaces. Put down the usual daytime phone number from Monday through Friday for the person. If there are two possible numbers, put both numbers down.

The doctor's name should be the name of the doctor that the person would see for most medical care needs.

Section 2:

Check one box to show who filled out this form. Put down the name and phone number of the person who filled out the form.

Section 3:

Tell us what trouble the person is having in getting medical care or medicine. Attach more paper if you need to. Check one or more of the blanks. This will help us know what the problem is.

Tell us if you got a letter or paper about the medical care or medicine. Be sure to write down the date on the letter or paper.

Tell us if a doctor told you to get the care or medicine you are having a problem with.

Section 4:

If you are getting a bill for care or medicine, tell us the date you got the bill.

Section 5:

If your trouble is with your medicine, fill in this section. Be sure to tell us the name of the doctor who ordered the medicine. Be sure to tell us if your drug store gave you some or all of the medicine. Be sure to tell us the name and phone number of your drug store.

Section 6:

Fill in this section if you have been getting the care but now it has been stopped or cut. Tell us if you still want the care.

Section 7:

Tell us if you need a quick decision about this care. Tell us why.

Section 8:

Sign this section if it is OK for us to see your medical records to help decide on your appeal.

Advance Directives

Living Will and Organ Donor Certification

Machines and medicine can sometimes keep people alive even after there is no hope for a cure. It used to be that the doctors decided how long someone should be kept alive.

Under the Tennessee Right to Natural Death Act, you can make your own choice. You can decide if you want to be kept alive by machines and for how long. You can do this with a “living will”.

A living will needs to be filled out while you can still think for yourself. The living will tells your friends and family how you would want a terminal illness to be treated.

Your living will needs to be signed in front of two witnesses. The witnesses may **not** be:

1. related to you by blood or marriage.
2. entitled to any of your belongings after you die.
3. your doctor or his or her employees of a health care facility where you are a patient.

One copy of your living will should be left with your PCP as part of your medical health records. One copy of your living will should be left with the person who you think would make a medical decision for you, if needed. Keep the original living will with your other important papers.

Once your living will is signed and witnessed correctly, it is your rule, unless you change your mind. As long as you can still think for yourself, you can decide about your health care without a living will.

The following form is a Living Will. If it is something you would like to have in place, fill it out and make copies for your doctor and family or friend. You do not have to fill this out. You may want to talk to a lawyer or friend before filling it out.

Living Will/Donor Form

Living Will

1 of 3

Living Will

I, _____, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare: If at any time I should have a terminal condition and my attending physician has determined there is no reasonable medical expectation of recovery and which, as a medical probability, will result in my death, regardless of the use or discontinuance of medical treatment implemented for the purpose of sustaining life, or life process, I direct that medical care be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medications or the performance of any medical procedure deemed necessary to provide me with comfortable care or to alleviate pain.

Artificially Provided Nourishment and Fluids:

By checking one of the lines below, I:

_____ Authorize the withholding or withdrawal of artificially provided food, water or other nourishment or fluids.

_____ DO NOT authorize the withholding or withdrawal of artificially provided food, water or other nourishment or fluids.

Organ Donor Certification

Notwithstanding my previous declaration relative to the withholding or withdrawal of life-prolonging procedures, if as indicated below I have expressed my desire to donate my organs and/or tissues for transplantation, or any of them as specifically designated herein, I do direct my attending physician, if I have been determined dead according to Tennessee Code annotated, 68-3-501(b), to maintain me on artificial support systems only for the period of time required to maintain the viability of and to remove such organs and/or tissues for transplantation.

Check one line below:

_____ Desire to donate my organs and/or tissues for transplantation.

_____ Desire to donate my _____.
(Write specific organs and/or tissues for transplantation)

_____ DO NOT desire to donate my organs or tissues for transplantation.

In the absence of my ability to give directions regarding my medical care, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical care and accept the consequences of such refusal.

The definitions of terms used herein shall be as set forth in the Tennessee Right to Natural Death Act, Tennessee Code Annotated, 32-11-103.

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

In acknowledgement whereof, I do hereinafter affix my signature on this

the _____ day of _____, 20____.
(date) (month) (year)

(Declarant-Your Signature)

We, the subscribing witnesses herto, are personally acquainted with and subscribe our names herto at the request of the declarant, an adult, whom we believe to be of sound mind, fully aware of the action taken herein and its possible consequence. We, the undersigned witnesses, further declare that we are not related to the declarant by blood or marriage; that we are not entitled to any portion of the estate of the declarant upon the declarant's decease under any will or codicil thereto presently existing or by operation of law then existing; that we are not the attending physician, an employee of the attending physician or a health facility in which the declarant is a patient; and that we are not persons who, at the present time, have a claim against any portion of the estate of the declarant upon the declarant's death.

(Witness)

(Witness)

STATE OF TENNESSEE
COUNTY OF _____

Subscribed, sworn to and acknowledged before me
by _____, the declarant, and subscribed and sworn to before
me by _____ and _____, witnesses, this
_____ day of _____, 20_____.

(Notary Public)

My Commission Expires: _____



Explanation of Coverage



Explanation of Coverage

INTRODUCTION

This explanation of Coverage explains your coverage by VHP. It lists services covered and any limits which may apply. It is your Explanation (description) of Coverage (EOC).

Please read this EOC and your Member Handbook. Together they describe your benefits, and explain how to use the plan. They also provide information and phone numbers you may need as a VHP member.

Any deductibles, copayments, and maximum out-of-pocket expenses that you must pay are listed on the front of your I.D. card.

Except in cases of emergency and except in cases where VHP has referred you to a non-VHP provider, all services must be provided by VHP providers, medical staff, hospitals and medical facilities. Services must be medically necessary.

Principal Benefits and Services

PROVIDER SERVICES

As Medically Necessary

INPATIENT HOSPITAL DAYS

As Medically Necessary

- ? Including days at a designated perinatal center
- ? Pre-admission approval and concurrent review required

OUTPATIENT HOSPITAL SERVICES

As Medically Necessary

LAB AND X-RAY SERVICES

As Medically Necessary

PREVENTIVE HEALTH SERVICES

NO ONE HAS TO PAY A COPAYMENT OR DEDUCTIBLE FOR PREVENTIVE SERVICES

Preventive and wellness care is care that keeps you well and finds health problems early.

The following is a list of covered preventive services which include but are not limited to:

- ? Regular checkups for adults and children
- ? Care for women expecting a baby
- ? Well baby care
- ? Shots for adults and children
- ? Tests for cholesterol, blood sugar, colon and rectal cancer, bone hardness, thyroid disease, diseases you get from having sex (i.e HIV, AIDS, etc.), pap smears, mamograms for breast cancer, urine tests, EKG tests for heart problems, tests for hearing, and tests for tuberculosis (PPD)
- ? Birth control information
- ?

NEWBORN SERVICES

As Medically Necessary

Includes circumcisions performed by a physician.

EPSDT (Early Periodic Screening, Diagnosis & Treatment)

UNDER EPSDT (EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT) COVERS THE FOLLOWING:

- ? Early Periodic Screening, Diagnosis and Treatment (EPSDT) for members under age 21.
- ? Regular, periodic visits to the doctor to see if the child is developing normally and to see if there are any physical or mental problems. This is called “screening” and needs to happen according to a regular schedule. For example, children from birth to age 2 are entitled to eleven (11) “screens”; from age 3 to age 11 (7) “screens”; and from age 12 to age 20, nine (9) “screens”. In addition, a child is entitled to a “screening” whenever the child is referred to a doctor by a teacher who notices a change which might require a screening; and
- ? Treatment, including rehabilitation, for any health problems (physical, mental or developmental) discovered during a “screening”; and regular visits to a dentist for check-ups and treatment; and
- ? Regular periodic tests of the child’s hearing and eyesight and treatment or any problems with hearing and eyesight; and
- ? Immunizations (shots) for diphtheria, tetanus, pertussis, hepatitis B vaccine, varicella (chicken pox), polio, measles, mumps, rubella (MMR) and HIB flu; and
- ? Routine lab tests, as well as tests for lead in blood and sickle cell anemia, if the child is in a

situation that might put him/her at risk for either or both; and

- ? Treatment for drug and/or alcohol problems (coverage provided by your BHO)

ADULT PREVENTIVE HEALTH SERVICES

Initial visits – Ages 19 and above
History

- ? Past medical history includes history of significant illnesses,
- ? Family history of medical conditions, such as hypertension, diabetes, cancer
- ? Present history of current problems or illnesses
- ? Review of body systems

Physical Exam

- ? Measurements: height, weight, pulse, blood pressure, etc.
- ? Physical examination
- ? Laboratory – as indicated
- ? Special counseling on health habits, nutrition, injury prevention, etc. as indicated
- ? Immunizations – tetanus – diphtheria booster every ten years or as indicated

Subsequent Visits

Age 19-39 years

- ? History – every 1-3 years
- ? Physical Exam – every 1-3 years
- ? Laboratory – pap smear every 1-3 years, total cholesterol and other tests for patients with special risk factors
- ? Special counseling, as indicated
- ? Immunizations – Tetanus – diphtheria booster every 10 years, patients with special risk factors; Hepatitis B pneumococcal

influenza (every year), measles-mumps-rubella

Age 40-64 years

- ? History – every 1-3 years
- ? Physical Exam – every 1-4 years
- ? Laboratory – pap smear every 1-3 years, total cholesterol and other tests for patients with special risk factors
- ? Special counseling, as indicated
- ? Immunizations – same as for 19 to 39 years except no measles, mumps, or rubella

Ages 65 years and above

- ? History – every year, also functional status and symptoms of transient ischemia
- ? Physical Exam to include hearing and visual acuity
- ? Mammogram – yearly screening
- ? Laboratory – thyroid levels (women), dipstick urinalysis, total cholesterol, patients with special risk factors, fasting glucose, tuberculosis test (PPD), EKG, pap smear every 1-2 years, stool sample for sigmoidoscopy/colonoscopy
- ? Special counseling, as indicated, including glaucoma testing
- ? Immunizations – Tetanus-diphtheria booster every 10 years, influenza every year, pneumococcal and as needed, Hepatitis B

EMERGENCY ROOM SERVICES

As Medically Necessary

CHIROPRACTIC SERVICES

When determined cost effective by VHP

PHARMACY SERVICES

As Medically Necessary

- ? Less than effective (LTE) drugs and identical, related or similar to LTE drugs are excluded.

DURABLE MEDICAL EQUIPMENT

As Medically Necessary

MEDICAL SUPPLIES

As Medically Necessary

HOME HEALTH CARE SERVICES

As Medically Necessary

HOSPICE CARE SERVICES

As Medically Necessary

(Must be provided by a certified organization, according to Medicare hospice requirements)

DENTAL SERVICES

As Medically Necessary

- ? Preventive, diagnostic and treatment services for enrollees under age 21. Services for enrollees age 21 or older are limited to cases of accidental injury to or neoplasm of the oral cavity, life threatening infection, accidental injury to natural teeth, including their replacement (limited to the cost of bridgework or the replacement of teeth injured in accident unless teeth implants are medically necessary) and the removal of impacted wisdom teeth. (The adult dental “accident must be caused by some external force, like a car accident, not by some normal act of mastication, or grinding of teeth while sleeping, or any other naturally occurring circumstance.)

- ? Orthodontics – limited to individuals under 21, except when an orthodontic treatment plan is approved prior to the enrollee attaining 21 years of age, and treatment is initiated prior to the recipient attaining 21 years of age, or when orthodontic treatment is the result of facial hemiatrophy or congenital birth defects (if enrollee was covered by TennCare at birth)

VISION SERVICES

As Medically Necessary

- ? Preventive, diagnostic and treatment services for enrollees under age 21 (including eyeglasses)
- ? First pair of cataract glasses or contact lens/lenses following cataract surgery is covered for adults as well as enrollees under age 21

EMERGENCY & NON-EMERGENCY AMBULANCE TRANSPORTATION SERVICES

As Medically Necessary

NON-EMERGENCY TRANSPORTATION SERVICES

- ? As necessary for enrollees lacking accessible transportation for covered services
- ? The travel to access primary care and dental services must meet the requirements of the waiver of terms and conditions. The availability of special services, as related to travel distance should meet the usual and customary standards of the community. However, in the event VHP is unable to negotiate such an arrangement for an enrollee,

transportation must be provided regardless of whether or not the enrollee has access to transportation. If the enrollee is a child, transportation must be provided for the child and an accompanying adult.

COMMUNITY HEALTH SERVICES

As Medically Necessary

REHABILITATION SERVICES

As medically necessary when determined cost effective by VHP. All medically necessary services show be provided to enrollees when 21 years of age as required by EPSDT.

RENAL DIALYSIS SERVICES

As Medically Necessary

RECONSTRUCTIVE BREAST SURGERY

Covers all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy as well as any surgical procedure on the non-diseased breast deemed necessary to establish symmetry between the two breasts in the manner chosen by the physician.

PRIVATE DUTY NURSING SERVICES

- ? As medically necessary and when prescribed by an attending physician for treatment and services rendered by a registered nurse (R.N.) or licensed practical nurse (L.P.N.), who is not an immediate relative.

SPEECH THERAPY SERVICES

- ? As medically necessary, by a Licensed Speech Therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder. All medically necessary services shall be provided to enrollees when 21 years of age in keeping with EPSDT requirements.

SITTER (HOME HEALTH AIDE) SERVICES

- ? As medically necessary, a sitter who is not a relative may be used where an enrollee is confined to a hospital as bed patient and certification is made by a network physician that R.N. or L.P.N. is needed and neither is available.

CONVALESCENT CARE SERVICES

- ? Upon receipt of proof that a Covered person has incurred Medically Necessary expenses related to convalescent care, the Plan shall pay for up to and including the one-hundredth (100th) day of confinement during any calendar year for convalescent facility(ies) room, board, nursing care, provided: (1) a physician recommends confinement for convalescence; (2) the enrollee is under the continuous care of a physician during the entire period of confinement; and (3) the confinement is required for other than custodial care.

DONOR ORGAN PROCUREMENT SERVICES

- ? As medically necessary for a covered organ transplant

SERVICES NOT COVERED

- 1) Services which are not medically necessary, except that preventive and EPSDT services shall be covered
- 2) Eyeglasses for members over age 21 (glasses or contact lens/lenses following cataract surgery are covered), hearing aids and non-emergency dental services for adults
- 3) Services performed for cosmetic purposes or performed mainly to improve appearance
- 4) Medical services for individuals committed to local, state or federal penal institutions.
- 5) Medical services performed outside the United States
- 6) Organ transplants or other medical procedures which are considered experimental or investigational, including the performance of a specific medical procedure which would be covered except for the fact that is used in a manner that is not a recognized mode of treatment for a specific medical condition
- 7) Weight reduction programs, intestinal by-pass surgery or gastric stapling for the treatment of obesity

- 8) Services for the treatment of impotence or infertility or for the reversal of sterilization
- 9) Autopsy/necropsy
- 10) Job-related illness or injury covered by Worker's Compensation
- 11) Pre-employment physical examinations
- 12) Fitness to duty examinations
- 13) Drugs which the Food and Drug Administration consider to be less than effective (LTE) or identical, related or similar (IRS) drugs which are counterparts of Less Than Effective drugs.
- 14) Drugs when prescribed for smoking cessation, hair growth, cosmetic purposes to beautify the skin, appetite suppression of weight reduction, treatment of impotence, or treatment of infertility.
- 15) Services are received (or incurred) before the effective date of your VHP coverage, or after its termination;
- 16) For personal hygiene, luxury or convenience items;
- 17) For services mainly for custodial care, or convalescent care or rest cures, except as specified;
- 18) For foot care only to improve comfort or appearance such as care of flat feet, subluxations, corns, bunions (except capsular and bone surgery), calluses, toenails;
- 19) For transsexual surgery or any treatment leading to or in connection with transsexual surgery;
- 20) For radial keratotomy or any other surgical procedure for the correction of a refraction error of the eye;
- 21) For an artificial heart, lung, liver or pancreas or any other artificial organ or any associated expense;
- 22) For services provided by a member of immediate family (spouse, parent, legal guardian, child, aunt, uncle, first cousin or any related by blood or marriage) or any person that lives in your household.