What Does the Plan Cover?

This section explains many of the health care services and benefits that Medicaid members can get through Kaiser Permanente when they need them.

Some services are only covered if we approve them first. Our decision has to be made by a qualified health care professional. We will tell you and your doctor of our decision.

If you get services that are not covered benefits, or if you get them outside our network, Kaiser Permanente may not cover those services and you may have to pay for those services.

If you need more information on what your plan does and does not cover, or about prior approval, call Member Services.

Copayments

There are no copayments for Medicaid covered services.

Prior approval (Service authorization)

You may be required to get prior approval for certain covered services. If your PCP decides you need a service that requires prior approval, he/she will send a request to us for you to receive this service. We will review the request and notify you and your PCP of the decision when the review is complete.

Talk to your PCP if you need a prior approval for any covered service or medical equipment. If you have a question or are not sure if a certain benefit requires prior approval, call Member Services at 855-249-5025, 866-513-0008 TTY/TDD for help. If your benefits change, we will notify you 30 calendar days before the change.

You do not need prior approval for some services including, but not limited to:

- Care provided at your PCP office, including your PCP's nurse or doctor's assistant
- Emergency and urgent care services
- Family planning services (in or out-of-network)
- Eye exams from an in-network eye doctor
- Preventive services

Services covered by Kaiser Permanente

Ambulance

We pay for an ambulance in an emergency or when medically necessary. We also pay if we call the ambulance to transfer you between medical facilities.

Behavioral health services—prior approval may be required

The following services are covered:

- Inpatient mental health or substance abuse treatment services in a psychiatric unit of a hospital
- Inpatient substance abuse treatment
- Outpatient member, family, and group behavioral health and substance abuse services
- Electroconvulsive therapy
- Medication management services
- Substance abuse assessment, evaluation, and services

Services given as a result of Temporary Detention Order (TDO) and Emergency Custody Order (ECO) are covered. A TDO is a court order that requires a person to be held in a psychiatric facility for a period of time. Kaiser Permanente will cover behavioral health services given as a result of a TDO except if you are age 21 through 64 and admitted to a state operated or private freestanding psychiatric facility. We also cover medically necessary screenings and assessments for you if you are under an ECO to determine if a TDO is necessary and to assess the need for hospitalization and treatment. If a judge determines that you can be transferred without medically harmful consequences, we may transfer you to another facility for care.

Clinic services, doctor visits, outpatient services

We cover services which are preventive, diagnostic, therapeutic, rehabilitative, or palliative when it is medically necessary, appropriate, and approved in outpatient hospital settings, clinic facilities, and doctor offices.

Coverage includes, but is not limited to, the following services:

- Immunizations
- Family planning services
- Preventive, therapeutic, and palliative services
- Physical therapy, occupational therapy, speech therapy, and audiology services
- Colorectal cancer screening in accordance with recommendations established by the American Cancer Society
- Prostate-specific antigen screening and related digital rectal exams for the screening of male enrollees for prostate cancer
- Sick-child visits for members up to 21 years old
- Renal dialysis

We do not cover a number of services, including, but not limited to:

- Cosmetic services, except for reconstructive breast surgery and cleft lip, cleft palate, or both
- Disposable supplies for the home including, but not limited to, bandages, gauze, tape, and antiseptics
- Experimental and investigational procedures, including clinical trials, unless medically needed per EPSDT
- Sexual reassignment

- Alternative medical services, including services of a chiropractor, acupuncturist, naturopath, massage therapist, or Christian Science nurse/ Sanatoria are not covered
- Biofeedback

Court ordered services

We cover all medically necessary court-ordered services, except for incarcerated individuals/ inmates.

Dental services

Members under the age of 21 can get routine dental services through the Smiles for Children Program. The toll-free number is 888-912-3456.

Kaiser Permanente provides coverage for some dental-related services for adults and children when it is medically necessary, appropriate, and approved, including:

- Anesthesia and hospitalization services for medically necessary dental services
- Dental services performed by a medical doctor or dentist as a result of a dental accident
- Preparation of the mouth for radiation therapy
- Medication for covered dental services
- Repair of cleft lip or cleft palate or both

Diabetic equipment and supplies

We provide coverage for the following when medically necessary:

- U.S. Food and Drug Administration–approved diabetic equipment
- Insulin pumps and supplies
- Home blood glucose monitors, lancets, blood glucose strips and insulin syringes and needles

Quantity limits may apply for home blood glucose monitors, lancets, blood glucose strips, insulin syringes and needles. In addition, some insulin delivery devices such as pens or cartridges require prior approval.

We do not cover diabetic shoes and inserts.

Durable Medical Equipment (DME)—prior approval required

We cover medical supplies and equipment when it is medically necessary, appropriate, and approved by your PCP.

Some of the medically necessary DME we cover include, but is not limited to, the following:

- Prosthetic services and devices including artificial arms, legs, and their necessary supportive attachments
- Orthotics including braces, splints, foot orthotics, or when recommended as part of an approved intensive rehabilitation program

- Ostomy supplies
- Apnea monitors and CPAP machines
- Remedial or adaptive devices such as implants or dental devices
- Wheelchairs
- Oxygen and oxygen equipment
- Canes, crutches, or walkers
- Supplies and equipment necessary to administer enteral nutrition and total parenteral nutrition

The following DME or supply items are not covered:

- Comfort, convenience, or luxury equipment or features
- Exercise or hygiene equipment
- Non-medical items such as sauna baths or elevators
- Modifications to your home or car
- Electronic monitors of the heart or lungs, except infant sleep apnea monitors
- Prosthetic and orthotic devices other than those listed as covered
- Diapers for routine use for children under 3 years old who have not been toilet trained
- Air conditioners, room humidifiers, air cleaners
- Furniture or appliances not defined as medical equipment

Maintenance and necessary repair of DME will be covered. Equipment that has been damaged due to neglect or abuse will not be repaired or replaced.

Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT)

These services are covered for members up to 21 years old at no cost. Coverage is available for services not normally covered by Medicaid or Kaiser Permanente. Check-ups are needed more often in children's first years and less often as they grow older (see check-up and vaccine schedule below). Screening tests, such as blood tests, give the doctor information about your child's health.

We will remind you of upcoming EPSDT appointments for your child. Here is what to expect at your child's EPSDT checkups:

- Height, weight and blood pressure checks
- Eye exams
- Hearing tests
- Lab tests
- Need for dental referral
- Immunizations (shots)
- Lead and tuberculosis—assessments and screening
- Mental and physical assessment
- Screening for behavioral health or substance abuse
- Medications, including Fluoride and multivitamins
- Referrals to specialist if problems found during exam
- Health education and guidance about your child's health care
- Education and guidance for growth and development
- Information regarding accessing care, appointments, advice nurse, after hours care

Immunization Schedule (Birth–6 years)

Vaccine ▼ Age ▶	Birth	1 month	2 months	4 months	6 months	9 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
Hepatitis B	**HepB**	**HepB**			**HepB**							
Rotavirus			**RV**	**RV**	**RV**							
Diphtheria, tetanus, pertussis			**DTaP**	**DTaP**	**DTaP**			**DTaP**				**DTaP**
Haemophilus influenzae type b			**Hib**	**Hib**	**Hib**		**Hib**					
Pneumococcal			**PCV**	**PCV**	**PCV**		**PCV**				**PPSV**	
Inactivated poliovirus			**IPV**	**IPV**	**IPV**							**IPV**
Influenza					**Influenza (Yearly)**							
Measles, mumps, rubella							**MMR**					**MMR**
Varicella							**Varicella**					**Varicella**
Hepatitis A							**Dose 1**				**HepA Series**	
Meningococcal						**MCV4**						

Range of recommended ages for all children

Range of recommended ages for certain high-risk groups

Range of recommended ages for all children and certain high-risk groups

Source: cdc.gov

Immunization Schedule (7–18 years)

Vaccine ▼ Age ▶	7–10 years	11–12 years	13–18 years
Tetanus, diphtheria, pertussis	**1 dose (if indicated)**	**1 dose**	**1 dose (if indicated)**
Human papillomavirus		**3 doses**	**Complete 3-dose series**
Meningococcal		**Dose 1**	**Booster at 16 years old**
Influenza	**Influenza (yearly)**		
Pneumococcal			
Hepatitis A	**Complete 2-dose series**		
Hepatitis B	**Complete 3-dose series**		
Inactivated poliovirus	**Complete 3-dose series**		
Measles, mumps, rubella	**Complete 2-dose series**		
Varicella	**Complete 2-dose series**		

Range of recommended ages for all children

Range of recommended ages for catch-up immunization

Range of recommended ages for certain high-risk groups

Source: cdc.gov

Emergency, post-stabilization, and urgent care services

Emergency, post-stabilization (screenings and follow-up services needed to maintain or improve your condition), and urgent care services are covered without prior approval at no cost to you. These services are covered whether we tell you to go or you decide to go.

Family planning services and supplies

Family planning services and supplies are covered without prior approval. This includes, but is not limited to:

- Services and supplies and drugs that delay or prevent pregnancy, including Federal Drug Administration-approved contraceptives
- Family planning health education

The following family planning services and supplies are not covered:

- Drugs, services, and procedures to treat erectile dysfunction
- Services to treat infertility or promote fertility
- Surrogacy services
- Voluntary sterilization such as tubal ligation or vasectomies without approval

Hearing screenings and hearing aids

Hearing aids are covered for all members under 21 years old. Hearing aids are covered twice every five years or more frequently if medically needed. Ear molds and hearing supplies, such as cleaning kits, are covered with each new hearing aid.

Hearing aid device-related repairs, fittings, and dispensation require prior approval.

Members under 21 years old get hearing screenings at every wellness visit through EPSDT. At a minimum, these services shall include diagnosis of and treatment for defects in hearing, including hearing aids. Speech and hearing assessment is part of each preventive visit for older children. All newborn infants will be given a hearing screening before discharge from the hospital after birth.

Home health services—prior approval required

Home health services, including nursing services, rehabilitation therapies, and home health aide services when it is medically necessary, appropriate, and approved, are covered. In addition, services provided by a licensed or certified health care professional on a part-time or interim basis when approved by your PCP and the health plan are also covered.

Medically necessary outpatient or home setting therapies are covered even if a child is also receiving therapies in a school. House calls which are determined to be medically necessary by your PCP are covered.

The following home health services are not covered:

- Community food service delivery arrangements
- Custodial care that primarily requires patient protective services rather than definitive medical and skilled nursing care services
- Domestic or housekeeping services unrelated to patient care
- Medical social services
- Services related to cosmetic surgery
- Services that would not be paid for by Medicaid if provided to an inpatient of a hospital

Inpatient hospital services—prior approval for non-emergency stays required

Inpatient stays in general acute care and certified rehabilitation hospitals are covered. If you are admitted to a hospital that is not in the Kaiser Permanente network, we will work with your doctor to transfer you to a hospital in our network once you are stable for transfer.

You have coverage for at least a 48-hour hospital stay following a radical or modified radical mastectomy and not less than 24 hours of inpatient care following a total or partial mastectomy with lymph node dissection for the treatment of breast cancer.

For cases where a newborn and mother or a newborn alone (mom remains in the hospital) is discharged earlier than 48 hours after the day of delivery, we will cover at least one (1) early discharge follow-up visit. The follow-up visit will include a maternal assessment and/or newborn assessment as outlined by DMAS.

We do not cover the following:

- Inpatient care at skilled nursing facilities
- A private room unless medically necessary
- Comfort items, including
    - Television or Radio
    - Telephone
    - Visitor meals

Laboratory and X-ray services

We cover laboratory and X-ray services when it is medically necessary, appropriate, and approved by your PCP or licensed practitioner.

Organ transplants—prior approval required

The following transplants for all members when it is medically necessary, appropriate, and approved by Kaiser Permanente are covered:

Organ transplant services	Covered for members under age 21	Covered for members age 21 and over
Kidney from cadaver or living donor	Yes	Yes
Corneas	Yes	Yes
Liver from cadaver or living donor	Yes	Yes
Heart	Yes	Yes
Lung	Yes	Yes
Heart and lung	Yes	No
Bone marrow	Yes	Yes for myeloma, lymphoma, breast cancer, or leukemia
Small bowel	Yes	No
Small bowel with liver	Yes	No
Pancreas	Yes	No

Any medically necessary transplant procedures that are not investigational or experimental will be covered for members under 21 years old with prior approval.

Podiatry

Reasonable and necessary diagnostic medical or surgical treatment of disease, injury, or defects of the foot is covered.

The following podiatric services are not covered:

- Routine foot care
- Treatment of structural misalignment not requiring surgery
- Cutting or removal of corns, warts or calluses
- Trimming of nails

Prescription drug coverage

Kaiser Permanente covers drugs on our preferred drug list. The preferred drug list is approved and updated regularly by our doctors, pharmacists, and other health care professionals. This list allows us to choose drugs that are safe and effective.

If you would like to check on the coverage of a specific drug, please contact Member Services. You may get a copy of our Preferred Drug List at **kp.org/formulary** or by calling Member Services.

There may be times when a preferred drug is not the right drug for your condition. Your MAPMG doctor or participating provider can request coverage of a non-preferred drug for you if he or she believes it is medically necessary. If you have questions or disagree with the decision, you can contact Member Services.

Prior approval for prescription drugs

If you have prior approval for a prescription drug from another Medicaid health plan, we will cover it.

Your MAPMG doctor or participating provider can request prior approval for coverage of a drug for you. Kaiser Permanente will act on such requests within one business day. You and your doctor will be notified in writing when a prescription is denied for coverage. For any questions about the prior approval process for prescription drugs, please call Member Services.

Private duty nursing—prior approval required

Medically necessary private duty nursing is covered for members under 21 years old when members:

- Meet medical necessity EPSDT guidelines
- Qualify for the technology assisted waiver and are in the screening process
- Require continuous nursing that cannot be met through home health

Private duty nursing is not covered in schools. School-based private duty nursing services are not covered by Kaiser Permanente, but are covered by DMAS.

Second opinions

If you're not sure about a medical decision, you can get a second opinion. Your plan covers a visit to another MAPMG doctor or participating provider at no cost to you.

Telemedicine

Your health plan covers telemedicine services when medically necessary, appropriate, and approved by your doctor. Telemedicine is the real time or near real time two-way transfer of medical information between health care professionals using audio/video to diagnose medical conditions.

Therapy services—prior approval required

The following therapy services are covered when it is medically necessary, appropriate, and approved by Kaiser Permanente:

- Audiology
- Chemotherapy

- Inhalation therapy
- Intravenous therapy
- Occupational therapy
- Physical therapy
- Radiation therapy
- Speech therapy

Tobacco dependence and treatment

Tobacco cessation services for pregnant women and members under 21 years old are provided when it is medically necessary, appropriate, and approved by a doctor (including both counseling and medication support).

Transportation

Transportation services are provided for emergency and non-emergency covered services. To schedule transportation for an appointment, call LogistiCare at 866-823-8349 at least 3 business days prior to your scheduled medical appointment.

Vision

Vision coverage by ophthalmologists, optometrists, and opticians is provided for all members for the following:

- Routine eye examinations
    - Once every two years for adults
    - Yearly for members less than 21 years old, through EPSDT
- Routine refractions once every 24 months

The following services are covered and need prior approval:

- Services for the treatment of diseases or injury to the eye
- Eye prostheses, regardless of the function of the eye when it is medically necessary

Vision coverage for members under 21 years old is provided for the following:

- Lenses
- Frames
- Repair of lenses or frames once every 12 months or more frequently if medically needed
- Contact lenses when it is medically necessary and approved

Women's health services

The following services are covered for women:

- Annual preventive exams and routine healthcare services, such as pap smears
- Mammograms for women 35 years old and older, consistent with the guidelines published by the American Cancer Society
- Reconstructive breast surgery and breast prostheses following a medically necessary removal of the breast
- Routine and medically necessary obstetric and gynecologic health care services

We cover a variety of supplies and services for pregnant women determined as having high risk pregnancies:

- Prenatal services (including assessment, patient education, nutritional assessment and counseling) and postpartum services up to 60 days after the pregnancy has ended
- HIV testing and counseling
- Nurse midwife services
- Services to treat a medical condition that may complicate pregnancy

- Smoking cessation counseling and nicotine replacement therapy
- Case management services for high risk pregnant women and infants up to age 2
- Blood glucose meters for pregnant women when medically necessary
- Screening, referral, monitoring, evaluation, and treatment for prenatal and postnatal depression
- Homemaker services for members with high risk pregnancies

Exclusions and limitations

There are certain services that your health plan does not cover but instead are covered by DMAS and certain services that are not covered by either your health plan or DMAS. This section describes the exclusions and limitations for covered services.

Services covered by DMAS

The following services are provided by DMAS, not Kaiser Permanente. We will work with you to coordinate these services.

- Abortions when determined by DMAS to comply with federal and state laws and rules
- Home- and community-based care waiver services for qualifying individuals. More information available at **www.dmas.virginia.gov/Content_pgs/ltc-wvr.aspx**
- Case management services for members with auxiliary grants
- Case management services for members with mental retardation
- Case management services for seriously mentally ill adults and emotionally disturbed children
- Case management services for youth at risk of serious emotional disturbance
- Case management services and private duty nursing services through Home and Community-based Care Services waivers (AIDS, individual and family developmental disabilities support, mental retardation, elderly or disabled consumer direction, day support, and/or Alzheimer's) and related transportation
- Community mental health rehabilitative services and mental retardation services
- Crisis intervention services, intensive outpatient services, opioid treatment, day and residential treatment, and case management services for substance abuse
- Residential day and substance abuse treatment for pregnant women
- Personal care services through EPSDT. Your PCP must complete an assessment to qualify for personal care services. Your PCP will send this assessment to DMAS and DMAS will notify your PCP if your request for personal care services is approved.
- Specialized infant formula for children and medical foods for individuals under 21 years old
- Lead contamination investigations
- Testing of fluoridation levels in water
- Routine dental services through the Smiles for Children Program and limited medically needed oral surgery services for adults 21 and over. Call Smiles for Children at 888-912-3456 for more information.
- School health services, which is any service given on school property including, but not limited to, physical therapy, occupational therapy, speech language therapy, psychological and psychiatric services, private

duty nursing services, medical assessments, audiology services, personal care services, and services that are part of an individualized education program.

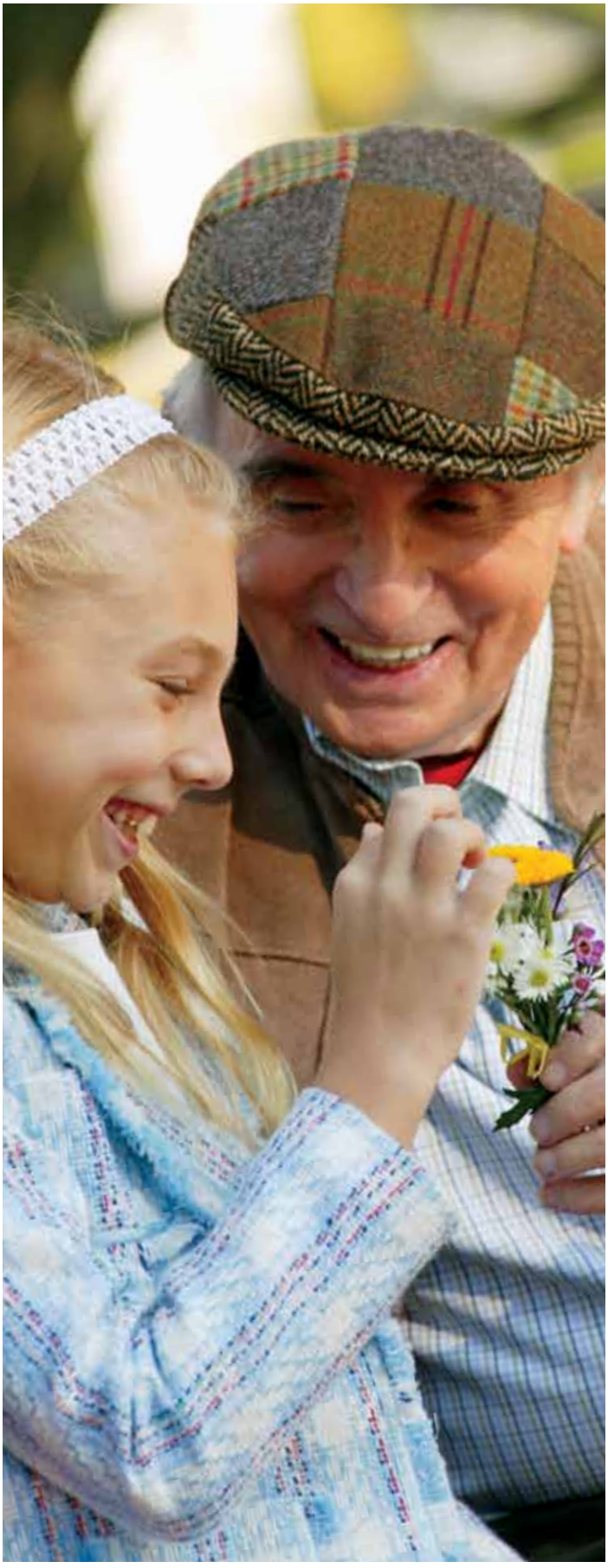
- Early intervention services through the Infant and Toddler Connection of Virginia. Your PCP must sign an Individualized Family Service Plan (FSP) to get these services. Contact Infant and Toddler Connection 804-786-3710 for more information about these services.
- Targeted case management services provided to seriously mentally ill adults and emotionally disturbed children; youth at risk of serious emotional disturbance; individuals with mental retardation; individuals with mental retardation and related conditions participating in home- and community-based care waivers; the elderly; and recipients of auxiliary grants

Talk to your PCP if you need to get these services. For information on how to access these services, contact the DMAS Managed Care Helpline at 800-643-2273.

Services not covered by Kaiser Permanente. Services covered directly through DMAS.

If your PCP decides that you need these services, you will be disenrolled from Kaiser Permanente and your care will be managed directly with DMAS. When you no longer need these services, you may return to Kaiser Permanente. The services include:

- Hospice services
- Skilled nursing facility care
- Members who are approved by DMAS as inpatients in long-stay hospitals, nursing facilities, or intermediate care facilities for the mentally retarded
- Members under age 21 who are approved for DMAS residential facility Level C programs as defined in 12 VAC 30-130-860
- Inpatient mental health services in state psychiatric hospitals



- Treatment foster care and residential treatment services for children
- Residential treatment facility services Level C for children under 21 years old, excluding members who are enrolled for childhood obesity/weight loss
- Members who are enrolled in a DMAS home- and community-based waiver prior to enrollment into the MCO, or members who are enrolled in the Technology Assisted Waiver at any time.
- Newly eligible members who are in the third trimester of pregnancy and who request exclusion within a department-specified timeframe of the effective date of their MCO enrollment
    - Exclusion may be granted only if the member's obstetrical provider (e.g., doctor, hospital, and/or midwife) does not participate with the enrollee's assigned MCO. Exclusion requests made during the third trimester may be made by the member, MCO, or provider. DMAS shall determine if the request meets the criteria for exclusion. Following the end of the pregnancy, these members shall be required to enroll to the extent they remain eligible for Medicaid.

Talk to your PCP if you need to get these services. For information on how to access these services, contact the DMAS Managed Care Helpline at 800-643-2273.

Kaiser Permanente will coordinate and refer enrollees to the following programs:

- Individuals with Disabilities Education Act
- Women's, Infants, and Children's Program
- Head Start
- Lead Environmental Investigation

Services not covered by Kaiser Permanente or DMAS

- Alternative medical services, including services of a chiropractor, acupuncturist, naturopath, massage therapist, or Christian Science Nurse/ Sanatoria
- Community food service delivery arrangements
- Cosmetic dental services, unless performed for medically necessary physiological reasons
- Cosmetic services, except for reconstructive breast surgery and cleft lip, cleft palate, or both
- Disposable supplies for home including, but not limited to, bandages, gauze, tape, and antiseptics other than as requested for medically necessary treatment
- Domestic or housekeeping services unrelated to patient care
- Drugs, devices, or procedures to treat erectile dysfunction
- Experimental and investigational procedures, including clinical trials
- Eye surgery solely for the purpose of correcting refractive defects of the eye, such as myopia, hyperopia, or astigmatism (e.g. LASIK)
- Cosmetic contacts
- Infertility services
- Medical social services
- Payment of a claim or any other demand or request for payment for a service received from a referral prohibited by law
- Routine dental services for members 21 years old and older
- Routine foot care, including treatment of structural misalignment not requiring surgery, cutting or removal of corns, warts or callus
- Routine infant formula
- Services for incarcerated individuals/inmates
- Sexual reassignment
- Surrogacy services