Chapter 6
KidzPartners (CHIP) Summary of Benefits

Purpose: This chapter provides an overview of the benefits available to KidzPartners members

Topics: Important topics from this chapter include:

- Summary of KidzPartners benefits
- Covered Services
- Non-Covered Services

Overview

This chapter provides an overview of the benefits KidzPartners members are entitled to and guidelines for appropriately utilizing authorizations.

Summary of Benefits

The following chart is a quick reference that lists many KidzPartners benefits and services and summarizes important guidelines. Additional information about covered and non-covered services follows this chart.

Prior authorization is **ALWAYS REQUIRED** for out-of-network services, except emergency/urgent care, family planning and dialysis services. Pregnant members already receiving care from an Out-of-Network practitioner at the time of enrollment may continue to receive services from that specialist throughout the pregnancy and postpartum period related to the delivery.

KidzPartners Benefits

The following table lists the benefits available to KidzPartners members and their related benefit limits, prior authorization requirements, and copays when applicable.

Table 6A: KidzPartners Benefits

Benefit/Service	Covered	Benefit Limit	Prior Authorization
Acupuncture	▪ Yes for members 16 years old or older	▪ 20 visits/year	▪ No
Advanced Diagnostic Radiology (MRI, CT, PET)	▪ Yes	▪ No	▪ Yes (Contact Evicore)
Ambulance (Emergent)	▪ Yes	▪ No	▪ No
Ambulatory Surgery Center/ Short Procedure Unit	▪ Yes	▪ No	▪ Yes
Annual Eye Exam	▪ Yes	▪ 1/year	▪ No

Table 6A: KidzPartners Benefits			
Benefit/Service	**Covered**	**Benefit Limit**	**Prior Authorization**
Audiology Services	▪ Yes	▪ No	▪ No
Autism Services	▪ Yes	▪ No	▪ No
Bariatric Surgery	▪ No	▪ No	▪ No
Chemotherapy	▪ Yes	▪ No	▪ No
Chiropractic Services	▪ Yes	▪ 20 visits/year	▪ No
Clinic (Outpatient Hospital, Independent & FQHC)	▪ Yes	▪ No	▪ No
Cosmetic Services	▪ No	▪ N/A	▪ Yes
Diagnostic Radiology (X-ray, US)	▪ Yes	▪ No	▪ No
Dental Services	▪ Yes	▪ See Dental section	▪ Contact Avesis
Durable Medical Equipment Purchase > $500	▪ Yes	▪ No	▪ Yes
Durable Medical Equipment Rental	▪ Yes	▪ No	▪ Yes
Elective Inpatient Surgical Care	▪ Yes	▪ No	▪ Yes
Emergency Services	▪ Yes	▪ No	▪ No
Eyewear (Contact, Lenses, or Frames)	▪ Yes	▪ See *Vision Care* section	▪ No (Contact Davis Vision)

Table 6A: KidzPartners Benefits			
Benefit/Service	**Covered**	**Benefit Limit**	**Prior Authorization**
Family Planning	▪ Yes	▪ No	▪ No
Fitness (Gym) Membership	▪ Yes	▪ Annual membership covered. Program requirements apply	▪ No
Hearing Aids	▪ Yes	▪ 1 hearing aid per ear every two years	▪ Yes
Home Infusion	▪ Yes	▪ No	▪ Yes
Home Health Nurses, Social Workers, Aids, and Therapists	▪ Yes	▪ No	▪ Yes
Hospice (Inpatient only)	▪ Yes	▪ No	▪ Yes (LOMN & COTI)
Infertility Treatment	▪ No	▪ N/A	▪ N/A
Inpatient Acute Hospital	▪ Yes	▪ No	▪ Yes
Laboratory	▪ Yes	▪ No	▪ No (Must use capitated lab)
Medical Diagnostics	▪ Yes	▪ No	▪ No
Medical/Surgical Supplies	▪ Yes (Diabetic supplies are covered under the RX benefit)	▪ No	▪ Yes (If >$500)
Non-Emergent Care Outside USA	▪ No	▪ N/A	▪ N/A
Non-Emergent Ambulance	▪ No	▪ No	▪ N/A

Table 6A: KidzPartners Benefits			
Benefit/Service	**Covered**	**Benefit Limit**	**Prior Authorization**
Nuclear Medicine	▪ Yes	▪ No	▪ No
Nutritional Supplements	▪ Yes	▪ No	▪ Yes (If >$500)
Obstetrical – Outpatient (Pre and Post-Natal)	▪ Yes	▪ No	▪ No
Orthotic (Diabetics only)	▪ Yes	▪ No	▪ Yes (If >$500)
Outpatient Physical, Occupational, and Speech Therapy	▪ Yes	▪ 30 visits/year for each type of therapy	▪ Yes (Contact Evicore)
PCP Visits (including CRNP, PA)	▪ Yes	▪ No	▪ No
Pharmaceutical	▪ Yes	▪ No	▪ Yes (If designated as prior authorization drug or non-formulary prescription)
Podiatrist Services (Routine)	▪ No	▪ N/A	▪ N/A
Preventative Physical Exam	▪ Yes	▪ No	▪ No
Private Duty Nursing (Inpatient)	▪ Yes	▪ No	▪ Yes
Prosthetic Device	▪ Yes	▪ No	▪ Yes (If > $500)
Radiation Therapy	▪	▪ No	▪ Yes (Contact Evicore)
Renal Dialysis (Emergent)	▪ Yes	▪ No	▪ No

Table 6A: KidzPartners Benefits			
Benefit/Service	**Covered**	**Benefit Limit**	**Prior Authorization**
Respite Care	▪ No	▪ N/A	▪ N/A
Skilled Nursing Facility	▪ Yes	▪ No	▪ Yes
Specialist visits (including CRNP, PA)	▪ Yes	▪ No	▪ No
Stress Echocardiography, Echocardiography, & Cardiac Nuclear Medicine Imaging	▪ Yes	▪ No	▪ Yes (Contact Evicore)
Tobacco Cessation	▪ Yes	▪ No	▪ No
Transportation (van service)	▪ No	▪ N/A	▪ N/A
Urgent Care	▪ Yes	▪ No	▪ No

Copays for KidzPartners Members

KidzPartners members may be responsible for copayments. This information is distributed to members through their Member Handbook on the KidzPartners section of our website, www.HealthPartnersPlans.com, and key copay information is printed on their member ID card.

All members enrolled in KidzPartners:

There are no CHIP copays for preventive care services, including well-child visits and visits for immunizations, for members in any premium category.

Members enrolled in "free" KidzPartners:

There are no CHIP copays for any services for any members enrolled in the free program.

Members enrolled in "low-cost" KidzPartners pay the following CHIP copays:

- $5 for visits to your children's primary care physician (PCP), except for well-child visits
- $5 for visits to specialists
- $25 for visits to the emergency room.
  - Copay is waived if your child is admitted
- $9 for brand name formulary drugs and $6 for generics

The annual maximum you will pay for copays is five percent of your family income.

Members enrolled in "full-cost" KidzPartners pay the following CHIP copays:

- $15 for visits to your children's primary care physician (PCP), except for well-child visits
- $15 for visits to specialist
- $50 for visits to the emergency room.
  - Copay is waived if your child is admitted.
- $18 for brand name formulary drugs and $10 for generics

Covered Services

The following section provides an overview of the services covered by KidzPartners. However, member benefits may vary and this section does not address specific benefit packages available to KidzPartners members. If a conflict exists between this document and the member's benefit package, the benefit package takes precedence.

- PCP referrals are not required to receive services from a specialist or a non-participating provider; however, an authorization is usually required for services performed by a non-participating provider.

Abortion Services

Abortion services are covered if the physician has determined, within the physician's best clinical judgment, as required by 18 PA. C.S. §3204, that the abortion is medically necessary to save the life of the mother. This information must be clearly documented in the member's medical record.

Acupuncture

KidzPartners covers acupuncture services for members age 16 and older. Services must be provided by a network provider specifically credentialed to perform acupuncture. Up to 20 visits yearly will be covered. No prior authorization or copay is required.

Ambulance

KidzPartners covers all emergency ambulance services with qualified transport services. All non-emergent transportation service is not covered.

Ambulatory Surgical Center/Short Procedure Unit (SPU)

For a procedure to be considered an Ambulatory Surgical or Short Procedure Unit (SPU) procedure, the care must involve all of the following services: (1) an operating room procedure; (2) general, regional or MAC (Monitored Anesthesia, Conscious) anesthesia; and (3) recovery room services. The procedure must be performed in connection with covered services. Claims for Ambulatory Surgery and SPU procedures must be billed using the appropriate national standard for billing code type, revenue codes, and procedures for all three services. All other procedures will be considered Outpatient Services. Prior authorization is required.

Asthma Checkups

If your patient has asthma, please refer the member to HPP Member Relations at **1-888-888-1211 (TTY 711)** for information on KidzPartners' Asthma Management program.

Chemotherapy

Chemotherapy treatment is a covered benefit for KidzPartners members.

Child Visits

Parents can make appointments with their children's PCP for well-child visits designed to keep them healthy. The primary and preventive care services children should have during these visits include:

- **Regular checkups:** From the time members are born, it is very important for children to visit their PCP regularly for well-child checkups, including routine blood pressure screening. Babies need checkups at 1, 2, 4, 6, 9, 12, 15, and 18 months; children need annual checkups starting at age 2. In addition to providing a comprehensive physical

exam, PCP should arrange for any needed lab or other diagnostic testing. These visits help assure children stay healthy.

- **Shots/Immunizations:** Children should have many important shots before age two in order for the shots to have the most effect. Children should also continue to have shots, including boosters and flu shots, as necessary. Whenever children see their PCP, be sure to check that their shots are up to date.

Chiropractic Care

Services of a state-licensed chiropractor are covered only to provide treatment for manual manipulation of the spine to correct a subluxation demonstrated by X-rays. No authorization is required when services are rendered by a participating physician. Contact eviCore for prior authorization. The benefit is limited to 20 visits per year.

Clinical Trials

Routine costs associated with Qualifying Clinical Trials. If your patient is eligible to participate in an approved clinical trial (according to trial protocol), with respect to treatment of cancer or other life-threatening disease or conditions, and either the referring provider is a participating provider who has concluded that participation in the trial would be appropriate, or you furnish medical and scientific information establishing that his or her participation in the trial would be appropriate, benefits shall be payable for routine patient costs for items and services furnished in connection with the trial. Health Partners Plans must be notified in advance of the member's participation in the qualifying clinical trial.

Covered Preventative Medications

Select medications such as contraceptives, iron supplements, sodium fluoride, folic acid supplements, vitamins, aspirin, smoking deterrents, vitamin D supplements, tamoxifen, and raloxifene are considered preventive medications and are covered at no cost to the member when filled at a participating pharmacy with a valid prescription. If you or the member have questions about whether a preventive medication is covered, call Member Services at **1-888-888-1211** (**TTY 711**).

Dental

KidzPartners contracts with Avesis, a dental benefits administrator/subcontractor. All members are offered dental services effective the first day of eligibility as KidzPartners members. Coverage includes:

- Diagnostic and Treatment Services
- Preventative Services,
- Palliative Treatment of Dental Pain
- Minor Restorative Services
- Endodontic Services
- Periodontal Services
- Prosthodontic Services
- Major Restorative Services.

Certain services, including all endodontic, prosthodontic, orthodontic, SPU and non-emergent oral and maxillofacial surgical services, require prior authorization by the dental benefits subcontractor. All dental procedure(s) that require hospitalization must be prior authorized by Health Partners Plans' Inpatient Services department. Appropriate documentation must be provided when requesting prior authorization.

Members can receive dental services from a participating primary care dentist. All they have to do is choose a dentist from the list of dentists in the online KidzPartners Provider Directory. The primary care dentist will coordinate members to periodontists and other dental specialists according to the policies defined by the dental subcontractor and approved by Health Partners Plans.

Diabetes Checkups

If your patient has diabetes, please refer the member to HPP Member Relations at **1-888-888-1211 (TTY 711)** for information on KidzPartners' Diabetes Management program.

Diabetes Self-Management Training and Education

Outpatient Diabetes Self-Management Training and Education services furnished to an individual with diabetes are covered by KidzPartners when performed by a provider with Outpatient Diabetes Education Program recognition from the American Diabetes Association. For more information or for help finding a participating provider, the member or PCP should call the Provider Services Helpline or members can call the Member Relations department (see the Contact Information section starting on page 1.13).

Diabetes Self-Management Supplies

Formulary diabetic test strips, lancets, glucose meters, syringes, and alcohol swabs are covered under the pharmacy benefit. These supplies can be obtained from any KidzPartners participating pharmacy with a prescription. Please refer to the formulary located at www.hpplans.com/formulary for more information.

Dialysis

Hemodialysis and peritoneal dialysis are covered benefits. Members requiring these services should be directed to a participating specialist. Most dialysis patients are eligible for Medicare benefits. In this case, KidzPartners becomes secondary insurance. Dialysis services do not need prior authorization.

Please remember to submit a 2728-U form for members with end-stage renal disease (ERSD). If a 2728-U form is not filed, KidzPartners' Enrollment department will contact the dialysis center and request a copy.

Durable Medical Equipment (DME)

Durable Medical Equipment is covered, so long as the provider directs patients to a KidzPartners participating DME vendor.

Key points to remember when prescribing DME items for KidzPartners members:

- All **purchased** DME items and outpatient services less than $500 per claim line DO NOT require prior authorization from KidzPartners.
- All DME **rentals** require prior authorization, regardless of reimbursement value.
- If any portion of a purchased customized DME device has a reimbursement value greater than $500, an authorization is required for the entire DME device.
- When the patient is renting a DME product covered by their previous insurer, it is the DME provider's responsibility to provide Health Partners Plans with the following information:
  - Clinical documentation
  - Physician orders
  - Number of months covered by the previous insurer
  - Termination date of the member's previous insurance coverage

If, at time of the member's transition, the DME rental is deemed medically necessary, Health Partners Plans will approve coverage up to a total maximum coverage period of 10 months (inclusive of the months covered by the previous insurer). If the DME rental is determined to not meet the criteria for medical necessity at time of the member's transition, the DME rental may only be approved for a period of up to two months (60 days) to ensure continuity of care.

- All special items that do not have their own HCPCS code (such as E1399) require prior authorization, regardless of reimbursement value.
- Authorizations are based on benefit coverage/medical necessity as defined in Chapter 7 – Utilization Management of this manual.

If you have questions, please call our Outpatient Services department during regular business hours. Providers who need help with urgent issues after business hours (about DME or such other outpatient services, such as discharge planning placements, and home care) can also call Outpatient Services (see the Contact Information section starting on page 1.13) and leave a message, which will be forwarded to an on-call nurse case manager.

Emergency Care

Emergency care and post-stabilization services in emergency rooms and emergency admissions are covered by KidzPartners for both participating and non-participating facilities, with no distinction for in- or out-of-area services. Copays may apply. Emergency care and post-stabilization services do not require prior authorization.

Non-par follow-up care for an emergency is covered by KidzPartners, but plan staff will outreach to the member to appropriately arrange for services to be provided in-network, whenever possible.

Emergency Services (Act 68)

Members are instructed to go to the nearest emergency room or call 911 for emergency care. An emergency medical condition is defined by the Commonwealth's Department of Human Services as 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 could reasonably be expected to result in:

- placing the health of the individual or, in respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;

- serious impairment to bodily function; or
- serious dysfunction of any bodily organ or part. Members are required to call their PCP as soon as possible after receiving emergency care, and to arrange follow-up care through their PCP.

Transportation and related emergency services provided by a licensed ambulance service shall constitute an emergency service if the condition is as described above.

Family Planning

Family planning counseling services are covered by our plan. If the PCP does not perform these services, he/she should refer the member to an obstetrician/gynecologist (Ob/Gyn), nurse midwife or a Family Planning Council site. Members have the option to self-refer to the Family Planning Council, Ob/Gyn, or nurse midwife without prior approval from a PCP. Members are not required to obtain family planning services from an in-plan provider. For further information, providers can call (on behalf of their members) KidzPartners Member Relations (see the Contact Information section starting on page 1.13).

Fitness Program Membership

Exercise helps children stay healthy and feel good about themselves. That's why KidzPartners offers special memberships at participating area YMCA's and other fitness centers. To qualify for a year-long membership at a participating center, members under 18 must complete six visits within the first three months. Members 18 and older must complete 12 visits during the 3 month introductory period, and have a $2 copay for each visit.

After completing these visits, no copay is required for the rest of their one-year fitness membership period. For further information and direction, members should call the Member Relations Helpline (see the Contact Information section starting on page 1.13).

Foot Care

Medical and/or surgical treatment of conditions of the feet, such as, but not limited to, bunions, ingrown toenails, plantar warts and hammer toes, are covered. Treatment of corns, calluses, nails of feet, flat feet, fallen arches, chronic foot strain or symptomatic complaints of the feet, are not covered unless associated with disease affecting the lower limbs which requires the care of a podiatrist or a physician. No prior authorization is needed.

Gynecological and/or Obstetric Examinations

The PCP may perform routine gynecological exams and/or refer members to gynecologists as appropriate. Members may self-refer to Ob/Gyn specialists or nurse midwives for any routine gynecological and/or maternity services without prior approval from a PCP. Members receiving maternity care from an out-of-network Ob/Gyn at the time of enrollment may continue to receive services from that provider throughout the pregnancy and postpartum period.

- Pennsylvania's Medical Assistance Program (Medicaid) requires all Obstetrical Needs Assessment Forms (ONAFs) to be submitted electronically online via eviCore Optum's portal at obcare.optum.com.

Providers can call Baby Partners to advise us of a pregnant member and/or members who are at risk of poor birth outcomes during business hours or our 24-hour Member Relations line to arrange to have their care coordinated by our care management team (see the Contact Information section starting on page 1.13).

Hearing Care Services

Hearing aids and devices and the fitting and adjustment of such devices are covered when determined to be medically necessary.

Benefits Limits: One routine hearing examination and one audiometric examination per 12 months. One hearing aid or device per ear every 24 months. Batteries for hearing aids and devices are not covered. **No monetary limits apply.**

Home Health Care

Home Care services are covered when medically necessary KidzPartners can facilitate the following care in the home when medically necessary: registered nurse, physical therapy, occupational therapy, speech therapy, and medical social worker intermittent visits. Prior authorization is required for all home health services except the initial evaluation. Parenteral and enteral nutrition, respiratory therapy, and IV antibiotic therapy are also covered home care benefits if they have been authorized prior to the care.

One maternity home health care visit may be provided within 48 hours of discharge and the second is recommended to take place within 21-56 days post-delivery. Additional post-delivery home care visits will require prior authorization.

Hospice Care

KidzPartners will refer members to a participating hospice if they wish to elect hospice coverage. Members may remain enrolled in KidzPartners even though they have elected hospice coverage. Members may continue to receive care unrelated to the terminal condition through KidzPartners and may also use a KidzPartners participating physician as their hospice attending physician. KidzPartners will cover hospice services when:

- A doctor certifies that the patient is terminally ill and is expected to live six (6) months or less; and
- A patient chooses to receive palliative care only instead of therapeutic care for the terminal illness; and
- Care is provided by a KidzPartners participating hospice program.

The hospice benefit is in-home palliative and supportive medical, nursing and other healthcare services, which are designed to meet the special physical, psychological, spiritual and social needs of dying members and their families (parents, siblings of a terminally ill child, and other persons involved in caring for the individual).

When hospice services in home are not able to be maintained due to lack of social support or symptom management, an inpatient setting may be indicated and would require prior authorization (see the Contact Information section starting on page 1.13).

Coverage includes:

- Physician and nursing services
- Medications including outpatient prescription drugs for pain relief and symptom management
- Physical, occupational and speech therapy
- Medical social services and counseling to beneficiary and family members

Hospital Services

All medical hospital admissions, including those admitted through the emergency room, as well as elective admissions, must be called in to our Inpatient Services department for authorization within two business days. Transfers to non-participating facilities require prior authorization before transfer occurs. Prior authorization is needed, except in the following instances:

- medical emergency;
- inpatient maternity services
- urgently needed services obtained outside of the service area;
- when the plan approves, in advance, a stay in a hospital that does not participate with KidzPartners.

After the effective date of coverage, medically necessary care will be provided until discharge including room, meals and general nursing care in a semi-private room (unless other accommodations are medically necessary):

- Physician services
- Special care units such as intensive care or coronary care units
- Special diets, when medically necessary
- Blood transfusions and their administration
- X-ray, laboratory and other diagnostic tests
- Services and supplies furnished by the hospital for inpatient medical and surgical treatment
- Operating and recovery room
- Oxygen, medication and anesthesia
- Use of durable medical equipment such as wheelchairs
- Rehabilitation services such as physical therapy, occupational therapy and speech pathology
- Inhalation therapy, chemotherapy, and radiation therapy
- Kidney, heart, heart/lung, lung, liver, bone marrow and corneal transplants for approved indications in Medicare-certified transplant facilities or transplant facilities approved by the plan
- Maintenance dialysis in an approved renal dialysis facility or hospital

The PCP (or the covering hospital physician or hospitalist) should make rounds on admitted patients regularly regardless of the provider admitting the patient. KidzPartners will look to the PCP for assistance in ensuring appropriate utilization of hospital services.

In the event of a serious or life-threatening emergency, the member should be directed to the nearest emergency facility.

Immunizations

All child immunizations are a covered benefit under the KidzPartners Preventive/Well-Child Care benefit.

Immunizations and Screenings

- Coverage will be provided for pediatric Immunizations (except those required for employment or travel), including the immunizing agents, which conform to the standards of the Advisory Committee on Immunization Practices (ACIP) of the Center for Disease Control (CDC), U.S. Department of Health and Human Services. Pediatric and Adult Immunization ACIP schedules may be found by accessing the following link: https://www.cdc.gov/vaccines/schedules/index.html.
- **Influenza Vaccines** can be administered by a participating pharmacy for members starting at the age of nine years old, with parental consent, according to PA Act 8 of 2015.
- **Health education:** A child's PCP will provide information and advice on important health issues, including prevention/cessation of all types of tobacco use, and healthy eating habits.
- **Developmental screening:** Checkups by a child's PCP will include screenings to check that your children's physical and learning development are on track.
- **Allergy diagnosis and treatment:** For children exhibiting symptoms of possible allergies, preventive care includes diagnosis and treatment.
- **BMI:** Body Mass Index (BMI) may help you determine whether the member is at risk for obesity.
- **Young women's health screens:** As your members become young women, routine women's health care should include checkups, Pap tests and breast exams. Check with the child's PCP for more information.

Injectables

Certain injectables, such as oncology products and/or home infusion/IV formulations, are covered as a medical benefit. For injectables covered under the pharmacy benefit, please see information about our Specialty Medication Program located in the Pharmacy section of this chapter. Please refer to the formulary located at www.hpplans.com/formulary for more information regarding specific coverage such as prior authorization, for specialty medications.

Laboratory

Outpatient laboratory services are provided through Quest Diagnostics. Locations of participating labs can be found via our online provider directory www.hpplans.com/provdirectory. Physicians must complete the requisition form. Stat lab work may be ordered from a KidzPartners participating hospital lab with a script. Laboratories must be CLIA-approved.

Mammograms

Screening mammographic examinations are covered annually. Members may self-refer for mammograms to any participating site that provides this screening. No authorization is needed if the provider is in the KidzPartners network.

Maternity Care

Prenatal care, delivery and postpartum care are covered. These services do not require prior authorization or PCP referrals. There are no limits to OB visits for prenatal care.

Through our Baby Partners program, KidzPartners provides all pregnant moms with important information about prenatal dental care (e.g., moms who take good care of their teeth have healthier babies). Dental insurance covers routine prophylaxis (including cleaning, scaling and polishing of teeth) once every 6 months, with the exception of a member under the care of a medical professional for pregnancy, who shall be eligible for one additional prophylaxis during pregnancy.

Staying with KidzPartners throughout your pregnancy will help assure that you and your baby receive all necessary care.

KidzPartners offers its pregnant members additional assistance through our Baby Partners program. For more information on our Baby Partners program, members can contact Member Relations at **1-888-888-1211** or the Baby Partners line at **1-866-500-4571 (TTY 711)**.

CHIP coverage will be extended to babies born to CHIP members for 31 days. It is important to apply for Medical Assistance or CHIP right after the birth of the child to provide continued coverage for the baby. Only one application needs to be completed to apply for both programs.

Maternity Services

A female member may select a participating provider for maternity and gynecological services without a referral or prior authorization. Hospital and physician care services relating to

antepartum, intrapartum, and postpartum care, including complications resulting from the member's pregnancy or delivery, are covered.

Under federal law, health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Coverage is also provided for at least one (1) home health care visit following an inpatient release for maternity care when the CHIP member is released prior to forty-eight (48) hours for a normal delivery and ninety-six (96) hours for a caesarean delivery in consultation with the mother and provider, or in the case of a newborn, in consultation with the mother or the newborn's authorized representative. Home health care visits include, but are not limited to: parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests, and the performance of any necessary maternal and neonatal physical assessments. A licensed health care provider whose scope of practice includes postpartum care must make such home health care visits. At the mother's sole discretion, the home health care visit may occur at the facility of the provider. Home health care visits following an inpatient stay for maternity services are not subject to copayments, deductibles, or coinsurance, if otherwise applicable to this coverage.

Medical Supplies

Perishable but medically necessary items that are used to treat injuries (including anklets, bandages, soft cervical collars, casts, cartilage knee braces, clavicle straps, wrist splints wrist/forearm splints, cock-up splints, elastic bandages, nasal splints, slings, finger splints, cold/hot packs, and straps for tennis elbow) and that have a specific HCPCS code do not require prior authorization from Outpatient Services if items are less than $500 per claim line.

Medical Visits

Outpatient medical visits performed in a physician's office, hospital, skilled nursing facility, or at home, by a KidzPartners participating physician/provider, are covered.

Member Education Classes

KidzPartners offers educational programs in many communities. Classes include ones to help children quit smoking, have a healthy baby, and become a better parent. KidzPartners also offers

education to help members deal with special health problems, like asthma. Information about these and other education sessions can be found in the member newsletter. Members can also call the Member Relations department for details about current classes.

Mental Health and Substance Abuse Treatment

Mental Health and Substance abuse services are provided through a subcontractor, Magellan Behavioral Health. There is no limits or copays for these services. All services other than emergency must be authorized by Magellan Behavioral Health. Members should call **1-877-710-8222** to obtain mental health or substance abuse services.

All drug and alcohol abuse treatment must be authorized by Magellan Behavioral Health.

Newborn Care

Newborns are covered under the mother's insurance for 31 days following birth. Services include, but are not limited to, routine nursery care, prematurity services, newborn hearing screens, preventive/well-child healthcare services and coverage for injury or sickness including the necessary care and treatment of medically-diagnosed congenital defects and birth abnormalities.

Orthodontics

KidzPartners offers comprehensive orthodontic treatment and other orthodontic services provided by the CHIP program. Services must be medically necessary and require prior authorization. Braces for cosmetic reasons are not covered.

Pediatric Preventive Care

Pediatric preventive care includes the following, with no cost-sharing or copays:

- Physical examination, routine history, routine diagnostic tests.
- Oral Health Risk Assessment, fluoride varnish for children ages five months -five years old (US Preventative Task Force Recommendation)
- Well baby care, which generally includes a medical history, height and weight measurement, physical examination and counseling.
- Blood lead screening and lead testing to detect elevated lead levels in the blood.
- Hemoglobin/Hematocrit to measure the size, shape, number and content of red blood cells.

Pharmacy

The KidzPartners drug benefit has been developed to cover medically necessary prescription products for self-administration in an outpatient setting. Non-self-administered drugs in the outpatient setting — not covered under the pharmacy benefit — are available through the contractual buy and bill process based on Health Partners Plans medical fee schedule. The KidzPartners formulary and prior authorization processes are key components of the benefit design. Health Partners Plans, through its Pharmacy department, provides prescription benefits for our members with the use of a closed formulary. The KidzPartners formulary covers many generic drugs, with exceptions such as DESI (Drug Efficacy Study Implementation) drugs, medications used for weight gain or loss (except for drug products being used to treat AIDS wasting and cachexia), drugs from manufacturers who do not participate in the Federal Rebate program, and agents used for cosmetic purposes. Generic drugs must be prescribed and dispensed when an A-rated generic drug is available.

The drugs listed in the KidzPartners formulary are intended to provide broad options to treat the majority of patients who require drug therapy in an ambulatory setting. The medications included in the formulary are reviewed and approved by the plan's Pharmacy and Therapeutics Committee, which includes practicing physicians and pharmacists from the Health Partners Plans provider community. The goal of the formulary is to provide safe and cost-effective pharmacotherapy based on prospective, concurrent, and retrospective review of medication therapies and utilization. The formulary as well as drug specific prior authorization forms are posted on our website at www.hpplans.com/formulary.

For additional printed copies, please call Health Partners Plans (see the Contact Information section starting on page 1.13).

A maximum of a 30-day supply of medication is eligible for coverage in an outpatient setting. Refills can be obtained when 80% of utilization has occurred. The prescriber is urged to prescribe in amounts that adhere to FDA guidelines and accepted standards of care.

The KidzPartners pharmacy benefit design features:

- No prescription limits for any group.
- Over-the-Counter (OTC) medications are covered. Specific covered agents are listed in the formulary.

- All groups have the same formulary and benefit design, but may differ in copayment amounts.
- Copayments do not apply to specialty medications, diabetic supplies including test strips, glucose meters and lancets.
- Preferred diabetic supplies including test strips, glucose meters, lancets, syringes and insulin are covered and processed under the pharmacy benefit according to the formulary.
- Specialty medications are covered and processed under the pharmacy benefit with prior authorization, if applicable. The specialty vendor will be utilized for these services unless prior approval has been provided by the Pharmacy department. Please refer to the formulary at www.hpplans.com/formulary for more information and specific drug coverage and to the specialty pharmacy page at https://www.healthpartnersplans.com/providers/clinical-info/specialty-medications-and-pharmacies..

Pharmacy Copay Design

Copayments for pharmacy benefits vary depending upon the level of coverage the member has. This design is:

- No Cost Group - no prescription copayments
- Low Cost Group - copayments include
  - $6 generics
  - $9 brand
- Full Cost Group - copayments include
  - $10 generics
  - $18 brand

The formulary covers preferred, medically necessary prescription products. Certain listed over-the-counter (OTC) medications, such as aspirin and acetaminophen, are formulary and are covered with a doctor's prescription. Blood glucose test strips, alcohol swabs, syringes and lancets (along with one blood glucose monitor per year) are only covered through the pharmacy benefit with a prescription. The preferred diabetic supplies can be found on the formulary located at www.hpplans.com/formulary.

Pharmacy Prior Authorization

There are specific medications on the formulary that require prior authorization. Drug specific prior authorization forms are available to help expedite the process with specific clinical criteria at www.hpplans.com/priorauth. There may be occasions when an unlisted drug or non-formulary is desired for medical management of a specific patient. In those instances, the unlisted medication may be requested through a medical exception process using the "Non-formulary Prior Authorization" form.

To ensure that select medications are utilized appropriately, prior authorization may be required for the dispensing of specific products. These medications may require authorization for the following reasons:

- Non-formulary medications, or benefit exceptions requested for medical necessity
- Medications and/or treatments under clinical investigation
- Duplication of Therapy Edits will be hard coded to assure appropriate utilization of multiple drugs within the same therapeutic categories (e.g., duplication of two SSRIs)
- All brand name medications when there is an A-rated generic equivalent available
- Prescriptions that exceed set plan limits (day's supply, quantity, refill too soon, and cost)
- New-to-market products prior to review by the P&T Committee
- Orphan Drugs/Experimental Medications
- Selected injectable and oral medications
- Specialty medications
- Drugs that exceed $1,000 in cost per prescription
- Drugs that exceed FDA prescribing limits

To request a prior authorization the physician or a member of his/her staff should contact Health Partners Plans' Pharmacy department at **215-991-4300** or toll free at **1-866-841-7659**. All requests can be faxed (**1-866-240-3712**) 24 hours per day; calls should be placed from 8:00 A.M. to 6:00 P.M., Monday through Friday. In the event of an immediate need after business hours, the call should be made to Member Relations at **1-888-888-1211**. The call will be evaluated and routed to a clinical pharmacist on-call (24/7).

The physician may use the Health Partners Plans drug specific forms or a letter of request, but must include the following information for a quick and appropriate review to take place:

- Specific reason for request
- Name and member number of member
- Date of birth of member
- Physician's name, license number, and specialty
- Physician's phone and fax numbers
- Name of primary care physician (PCP) if different
- Drug name, strength, and quantity of medication
- Day's supply (duration of therapy) and number of refills
- Route of administration
- Diagnosis
- Formulary medications used, duration and therapy result, and documentation such as pharmacy records or chart notes
- Additional clinical information that may contribute to the review decision such as specific lab results

All forms should be legible and completely filled out. All prior authorization forms are available at www.hpplans.com/priorauth.

Upon receiving the prior authorization request from the prescriber, Health Partners Plans will render a decision within 24 hours. Approval or denial letters are mailed to the member or parent/guardian, in the case of a child. A copy of the member letter will also be faxed or mailed to the prescribing physician. At any time during normal business hours, the prescribing physician can discuss the denial with a clinical pharmacist or can have a peer-to-peer discussion with the medical director by calling the Pharmacy department at **215-991-4300**.

Whenever the Pharmacy department is unavailable for consultation or prior authorization for a new medication, an automated five (5) day supply of medication (if FDA approved) can be dispensed at the point of sale at the discretion of the dispensing pharmacist. In the case of a refill for a medication used continuously without a break of more than 30 days, or a PRN (as needed) medication used without a break of more than six months, a 15-day supply can be dispensed. This automated override is available one time per member per medication per year. Prior to dispensing of medication, the pharmacy must confirm member eligibility.

If a member presents a pharmacy with a prescription, which requires prior authorization, whether for a non-formulary drug, or otherwise, and if the prior authorization cannot be processed

immediately, the plan will allow the pharmacy to dispense an interim supply of the prescription under the following circumstances:

- If the recipient is in immediate need of the medication in the professional judgment of the pharmacist and if the prescription is for a new medication (one that the recipient has not taken before or that is taken for an acute condition), the plan will allow the pharmacy to dispense a 5-day supply of the medication to afford the recipient or pharmacy the opportunity to initiate the request for prior authorization.
- If the prescription is for an ongoing medication (one that is continuously prescribed for the treatment of an illness or condition that is chronic in nature in which there has not been a break in treatment for greater than 30 days), the plan will allow the pharmacy to dispense a 15-day supply of the medication automatically, unless the plan mailed to the member, with a copy to the prescriber, an advanced written notice of the reduction or termination of the medication at least 10 days prior to the end of the period for which the medication was previously authorized.

Health Partners Plans will respond to the request for prior authorization within 24 hours from when the request was received. If the prior authorization is denied, the recipient is entitled to appeal the decision through several avenues. The 5-day or 15-day requirement does not apply when the pharmacist determines that taking the medication, either alone or along with other medication that the recipient may be taking, would jeopardize the health and safety of the member.

The goal of the drug benefit program is to provide safe and cost-effective pharmacotherapy to our members.

Physical Therapy (PT)/Occupational Therapy (OT)/Speech Therapy (ST)

Members may be referred for outpatient PT/OT/ST to a participating KidzPartners provider. Prior authorization is required for all outpatient PT/OT/ST. Requests should be addressed to Evicore, our delegated vendor. Prior authorization is not required for outpatient evaluation. This benefit covers up to 30 visits per year for each type of therapy.

Please note: Home Health Care is offered with no copayments and no limitations. This benefit can only be provided to a CHIP member who is homebound by a home health care provider in the CHIP member's home within the service area.

Preventive "Well Child" Services

Preventive health services are designed to ensure early detection and treatment of conditions and illnesses in KidzPartners members. Services include physical examinations, immunizations, dental care, vision testing and treatment, hearing testing, and screening for certain medical conditions. Certain counseling services, such as pregnancy and STD prevention for sexually active adolescents, are also included.

Our Pediatric and Adolescent Preventive Care Flow Sheets, Screening Schedule, and Pediatric Immunization Schedule are designed to assist PCPs in delivering services. For more information, visit www.HealthPartnersPlans.com and refer to the "Clinical Information" web page within the Provider section. PCP success in delivering these vital pediatric preventive services in accordance with these standards will be closely audited by the plan. Please recognize that CHIP may cover services that are not on the Medical Assistance fee schedule, or that exceed the fee schedule in amount, duration or scope. Contact the plan for further information.

Primary and Preventive Health Services

KidzPartners periodically reviews the Primary and Preventive Care Covered Services based on recommendations from organizations such as The American Academy of Pediatrics, the American College of Physicians, the U.S. Preventive Services Task Force (USPSTF) (all items or services with a rate of A or B in the current recommendations), the American Cancer Society and the Health Resources and Services Administration (HRSA). Examples of covered "USPSTF A" recommendations are folic acid supplementation, chlamydial infection screening for non-pregnant women, and tobacco use counseling and interventions. Examples of covered "USPSTF B" recommendations are dental cavities prevention for preschool children, healthy diet counseling, oral fluoride supplementation/rinses and vitamins, BRCA risk assessment and genetic counseling and testing, prescribed Vitamin D, prescribed iron supplementation, mineral supplements, chlamydial infection screening for pregnant women, and sexually transmitted infections counseling. Examples of covered HRSA-required benefits include all Food and Drug Administration approved contraceptive methods, sterilization procedures, breast feeding equipment, and patient education and counseling for all women with reproductive capacity. All services required by HRSA are covered. Accordingly, the preventive services are provided at no cost to the member.

Prosthetics/Orthotics

Purchase and fitting of prosthetic devices and supplies which replace all or part of an absent body organ and its adjoining tissues or replace all or part of the function of a permanently useless or malfunctioning body organ require prior authorization by the plan's Inpatient or Outpatient Services department.

Radiation Therapy

Radiation therapy services are covered and require prior authorization. Requests should be addressed to Evicore, our delegated vendor.

Reconstructive Surgery

Reconstructive Surgery will only be covered when required to restore function following accidental injury, result of a birth defect, infection, or malignant disease in order to achieve reasonable physical or bodily function; in connection with congenital disease or anomaly through the age of 18; or in connection with the treatment of malignant tumors or other destructive pathology which causes functional impairment; or breast reconstruction following a mastectomy.

Mastectomy and Breast Reconstruction: Benefits are provided for a mastectomy performed on an inpatient or outpatient basis, and for the following:

- Surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy, surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Coverage for initial and subsequent prosthetic devices to replace the removed breast or portions thereof, due to a mastectomy; and
- Physical complications of all stages of mastectomy, including lymphedemas.
- Coverage is also provided for one Home Health Care visit, as determined by the member's physician, received within forty-eight (48) hours after discharge.

Rehabilitation

Inpatient Rehabilitation services (medical and mental health are covered) in a KidzPartners participating rehabilitation facility. Inpatient rehabilitation requires prior authorization.

Skilled Nursing Facility

Inpatient care in a Skilled Nursing Facility (SNF) is covered in a KidzPartners participating skilled nursing facility. Services must be prior authorized by the plan's Inpatient Services department. Medically necessary skilled nursing and related services are covered on an inpatient basis in semi-private accommodations for patients requiring skilled nursing services, but not requiring confinement in a hospital.

Smoking Cessation

Various smoking cessation services are available to our members to assist them in quitting smoking. Please visit our website at www.HealthPartnersPlans.com for the most current reimbursable expenses. Smoking cessation programs generally include scheduled activities and meetings designed to help participants stop the habit of smoking. These programs are a covered benefit for KidzPartners members and do not require prior authorization from the member's PCP.

Specialist Visits

Services by non-participating physicians and other licensed non-participating allied health personnel will be covered only when prior authorized by the plan. Referrals are not required to receive care regardless of the provider participation status.

Specialty Medication Program

Health Partners Plans supports appropriate use of specialty medications and has established suppliers as well as procedures for appropriate prescribing and monitoring. Under the direction of the Health Partners Plans Pharmacy department, the physician provider has the primary responsibility for obtaining prior authorization for medications included in this program. The prescribing physician will need to send the completed medical request to the Health Partners Plans Pharmacy department by fax with all pertinent lab information at **1-866-240-3712**.

Specialty medications are higher cost, biologics, injections or oral medications that require special handling, monitoring, or have limited distribution per manufacturer or FDA guidelines. Specific specialty pharmacy vendors who have met high quality measures and accreditation are contracted with Health Partners Plans to handle and distribute these medications.

All requests for prior authorization are reviewed by the Pharmacy department for approval. Approvals, including approvals for shorter durations, are coordinated with the contracted specialty vendor for distribution to the provider's office or member's home.

In addition, the prescriber can always call Health Partners Plans' Pharmacy department at **215-991-4300** for assistance with prior authorization on specialty medications and preferred specialty vendors. Specific specialty prior authorization forms are available at www.hpplans.com/priorauth.

Certain medications, including the following medications, can be obtained through the retail pharmacy benefit without prior authorization:

- ceftriaxone
- diphenhydramine
- epinephrine (bee sting kits)
- fluphenazine decanoate
- Glucagon Emergency Kit
- Insulin
- haloperidol decanoate
- heparin
- methylprednisolone
- Penicillin G
- triamcinolone
- vitamin B-12

Certain specialty medications are processed through the Pharmacy department and require a prior authorization. Please refer to the formulary and the website for more information regarding specialty medications, drug specific prior authorization forms, and preferred vendors. For further information visit our specialty page https://www.healthpartnersplans.com/members/health-partners/resources/prescription-drug-information/specialty-medications-and-pharmacies

Suturing

PCPs are reimbursed fees for suturing performed in their offices.

Transportation (Non-Emergent)

Non-emergent transportation services are not covered.

Vision Care

KidzPartners covers vision care for all members through our subcontracted provider, Davis Vision. Members can choose a vision care provider from the online KidzPartners Provider Directory.

Visits for routine eye exams and glasses or medically necessary contacts are covered. A participating vision provider must be used. There are no copayments for routine eye examinations.

*If any vision service is provided under the medical benefit for a diagnosis of cataracts, keratoconus or aphakia, then a copayment may apply.

Frames and Lenses: One set of eyeglass lenses that may be plastic or glass, single vision, bifocal, trifocal, lenticular lens powers and/or oversize lenses, fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses, polycarbonate prescription lenses with scratch resistance coating and low vision items.

Frequency of eye exam: One routine examination and refraction every 12 months. The examination includes dilation, if professionally indicated. There is no cost to member in network services. There is no coverage for out-of-network *.

Frequency of lens and frame replacement: One pair of eyeglasses every 12 months, when medically necessary for vision correction.

Lenses: In Network – One pair covered in full every calendar year. There is no coverage for out-of-network.*

There are no copayments for covered standard eyeglass lenses (single vision, conventional (lined) bifocal, conventional (lined) trifocal, and lenticular).

Note: Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses.

Polycarbonate lenses are covered in full for children, monocular patients and patients with prescriptions > +/- 6.00 diopters.

All lenses include scratch resistant coating.

There may be copayments for optional lens types and treatments:

Ultraviolet Protective Coating	No Copay
Polycarbonate Lenses (if not child, monocular or prescription >+/-6.00 diopters)	$30
Blended Segment Lenses	$20
Intermediate Vision Lenses	$30
Standard Progressives	$50
Premium Progressives (Varilux®, etc.)	$90
Photochromic Glass Lenses	$20
Plastic Photosensitive Lenses (Transitions®)	$65
Polarized Lenses	$75

Standard Anti-Reflective (AR) Coating	**$35**
Premium AR Coating	**$48**
Ultra AR Coating	**$60**
Hi-Index Lenses	**$55**

Frames: Collection Frame – no cost to member.** Non-collection frame: Expenses in excess of $130 allowance payable by member. Additionally, a 20% discount applies to any amount over $130.** There is no coverage for out-of-network services.*

Replacement of lost, stolen or broken frames and lenses, (one original and one replacement per calendar year), when deemed medically necessary.

Contact Lenses: One prescription every year – in lieu of eyeglasses or when medically necessary for vision correction.

Expenses in excess of a $130 allowance (may be applied toward the cost of evaluation, materials, fitting and follow-up care). Additionally, a 15% discount applies to any amount over $130.**

Note: In some instances, participating providers charge separately for the evaluation, fitting, or follow-up care relating to contact lenses. Should this occur and the value of the Contact Lenses received is less than the allowance, members may submit a claim for the remaining balance (the combined reimbursement will not exceed the total allowance).

**Out-of-network exclusion only applies if child is in their coverage area at time of eyeglass/contact replacement. If a child is unexpectedly out of the area, e.g. vacation, and they need replacement contacts or eyeglasses, their expenses can be sent to the plan for reimbursement.*

***Note: Additional discounts **may be** available from participating providers.*

Expenses in excess of $600 for medically necessary contact lenses, with pre-approval — these conditions include:

Aphakia, pseudophakia or keratoconus, if the patient has had cataract surgery or implant, or corneal transplant surgery, or if visual activity is not correctable to 20/40 in the worse eye by use of spectacle lenses in a frame but can be improved to 20/40 in the worse eye by use of contact lenses.

KidzPartners covers routine vision exams. (Treatment of other eye problems may be covered as a medical benefit. The child's PCP can refer you to an eye specialist if necessary.)

When your children need a vision exam, just check your KidzPartners Provider Directory or call Member Relations at **1-888-888-1211 (TTY 711)** for help finding a convenient vision care provider. When you call to make an appointment, be sure to tell the office your children are members of KidzPartners. Remember to bring your children's membership ID cards with you to the appointment.

Vision benefit for children also includes one comprehensive low vision evaluation every 5 years, with a maximum charge of $300; maximum low vision aid allowance of $600 with a lifetime maximum of $1,200 for items such as high-power spectacles, magnifiers and telescopes; and follow-up care - four visits in any five year period, with a maximum charge of $100 per visit.

Providers will obtain the necessary pre-authorization for these services. The benefit is not covered if performed by an out of network provider.

Well Woman Preventive Care

There is no cost sharing for preventative services under the services of family planning, women's health, and contraceptives.

Well Woman Preventive Care includes services and supplies as described under the Women's Preventive Services provision of the Patient Protection and Affordable Care Act. Covered Services and Supplies include, but are not limited to, the following:

- **Routine Gynecological Exam, Pap Smear**: Female Members are covered for one (1) routine gynecological exam each year. This includes a pelvic exam and clinical breast exam; and routine Pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists. Female Members have "direct access" to care by an Obstetrician or Gynecologist. This means there is no Primary Care Physician referral needed.
- **Mammograms**: Coverage will be provided for screening and diagnostic mammograms. Benefits for mammography are payable only if performed by a qualified mammography service provider who is properly certified by the appropriate state or federal agency in accordance with the Mammography Quality Assurance Act of 1992. Copayments, if any, do not apply to this benefit.
- **Breastfeeding:** Comprehensive support and counseling from trained providers; access to breastfeeding supplies, including coverage for rental of hospital-grade breastfeeding pumps under DME with medical necessity review; and coverage for lactation support and counseling provided during postpartum hospitalization, Mother's Option visits, and

obstetrician or pediatrician visits for pregnant and nursing women at no cost share to the Member.

- **Contraception**: FDA-approved contraceptive methods, including contraceptive devices, injectable contraceptives, IUDs and implants; voluntary sterilization procedures, and patient education and counseling, not including abortifacient drugs, at no cost share to the member. Contraception drugs and devices are covered under the prescription drug benefit issued with the plan.
- **Osteoporosis Screening (Bone Mineral Density Testing or BMDT):** Coverage is provided for Bone Mineral Density Testing using a U.S. Food and Drug Administration-approved method. This test determines the amount of mineral in a specific area of the bone. It is used to measure bone strength, which is the aggregate of bone density and bone quality. Bone quality refers to architecture, turnover and mineralization of bone. The BMDT must be prescribed by a professional provider legally authorized to prescribe such items.

Non-Covered Services

The following services and benefits are excluded or limited under the KidzPartners plan:

- Artificial insemination/infertility treatment
- Cosmetic surgery, except to correct a serious disfigurement or deformity caused by disease or injury that occurred while the patient was a participating member; or for the treatment of congenital anomalies to restore a part of the body to its proper function
- Health club memberships except when stipulated by contract with the plan
- Personal convenience items or services
- Reversal of tubal ligation
- Services available through other programs such as workers' compensation, Veterans Administration, other governmental programs/agencies or other insurance coverage
- Services for which neither the member nor another party on his or her behalf has any legal obligation to pay
- Services not provided by, or arranged through a provider, medical office, or dental office participating with KidzPartners, except for emergency services, unless authorized by the plan
- Services not reasonable or medically necessary for the diagnosis or treatment of an illness or injury, or for restoration of physiologic function (except preventive services)
- Services performed by immediate relatives of members, or by others in the member's household
- Non-Emergent Transportation services

Medical Directors will not approve services that are deemed harmful to our members, are of inferior quality, or are medically unnecessary (as may be the case with a serious and clearly preventable adverse event). In addition, based on CMS guidelines, financial compensation for any and all services rendered as a result of, or increased by, a preventable serious adverse event will be withheld or recovered.