

## SECTION [XVII]

### ADDITIONAL BENEFITS FOR CERTAIN ESSENTIAL PLAN SUBSCRIBERS

*{Drafting Note: Insert the appropriate section number, following the order of provisions in the Table of Contents. Use this section only for Essential Plan 3 and Essential Plan 4 products (e.g., those whose income is at or below 138% of FPL)}*

Please refer to the Schedule of Benefits section of this [Contract; Policy] for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

#### A. Dental Services

**1. Covered Dental Services.** We Cover regular and routine dental services such as preventive dental check-ups, cleaning, x-rays, fillings and other services to check for any changes or abnormalities that may require treatment and/or follow-up care for you. You do not need a referral from your PCP to see a dentist.

We Cover crowns when Medically Necessary. Preauthorization is required.

We Cover root canal therapy when Medically Necessary.

We Cover crown lengthening only when associated with Medically Necessary crown or root canal procedure. Preauthorization is required.

**2. How to Access Dental Services.** If You need to find a dentist or change your dentist, please call [name of Dental Vendor] at [insert number and days/times] or please call Us at [insert number and days/times]. Customer Service Representatives are there to help You. Many speak Your language or have services that will translate in any language You need.

**3. Orthodontia Services.** Orthodontia is Covered when You have a Medically Necessary surgical treatment, such as reconstructive surgery of your jaw.

**4. Prosthodontics.** We Cover removeable complete or partial dentures, including six (6) months post-delivery care when they are required to alleviate a serious health condition or one that is determined to affect employability. This service requires Preauthorization.

Complete dentures and partial dentures whether unserviceable, lost, stolen, or broken will not be replaced for a minimum of eight (8) years from initial placement except when determined Medically Necessary by Us. Preauthorization requests for replacement dentures prior to eight years must include a letter from Your dentist explaining the specific circumstances that necessitate replacement of the denture. If replacement dentures are requested within the eight (8) year period after they have already been replaced once, then supporting documentation must include an

explanation of preventative measures instituted to alleviate the need for further replacements.

### **General Guidelines for All Removable Prosthesis:**

Complete and/or partial dentures will be approved only when the existing prosthesis is not serviceable and cannot be relined or rebased. Reline or rebase of an existing prosthesis will not be covered when such procedures are performed in addition to a new prosthesis for the same arch within six (6) months of the delivery of a new prosthesis. Only "tissue conditioning" is covered within six (6) months prior to the delivery of new prosthesis.

Cleaning of removable prosthesis or soft tissue not directly related to natural teeth or implants is not a covered service. Prophylaxis and/or scaling and root planning is only covered when performed on natural dentition.

"Immediate" prosthetic appliances are not a covered service.

#### **Other Removable Prosthetic Services**

"Tissue conditioning" for treatment reline using materials designed to heal unhealthy ridges prior to more definitive final restoration is the ONLY type of reline covered within six (6) months prior to the delivery of a new prosthesis. Insertion of tissue conditioning liners in existing dentures is limited to once per denture unit.

**5. Implant Services.** Dental implants will be Covered when Medically Necessary. Preauthorization is required for implant services.

Preauthorization requests for implants must have supporting documentation from Your dentist. Your dentist's office must document, among other things, Your medical history, current medical conditions being treated, list of all medications currently being taken, explaining why implants are Medically Necessary and why other covered functional alternatives for prosthetic replacement will not correct Your dental condition, and certifying that You are an appropriate candidate for implant placement. If Your dentist indicates that You are currently being treated for a serious medical condition, documentation from Your treating physician may be required.

### **B. Vision Services.**

**1. Covered Vision Services.** [We offer vision care through a contract with (name of Vendor), an expert in providing high quality vision services.] We Cover the following vision services:

- Services of an ophthalmologist, ophthalmic dispenser, and optometrist, and coverage for contact lenses, polycarbonate lenses, artificial eyes, and/or

replacement of lost or destroyed glasses, including repairs, when medically necessary. Artificial eyes are covered as ordered by a Participating Provider;

- Eye exams, generally every 12 months, unless medically needed more often
- Low-vision exam and vision aids ordered by Your doctor
- Specialist referrals for eye diseases or defects.

**2. How to Access Vision Services.** If You need to find a vision Provider or change Your vision Provider, please call [name of Vendor] at [insert number] or please call Us at [insert number and days/times].

### **C. Non-prescription Drugs (Over-the-Counter or OTC)**

In addition to the Prescription Drug Coverage described in Section [], We also Cover non-prescription (OTC) drugs, medical supplies, and hearing aid batteries when ordered by a licensed Provider.

### **D. Foot Care Services**

We Cover routine foot care provided by licensed Provider types when Your physical condition poses a hazard due to the localized presence of an illness, injury or symptoms involving the foot, or when performed as a necessary and integral part of otherwise Covered Services such as the diagnosis and treatment of diabetes, ulcers and infections. We do not Cover routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, cleaning or soaking feet, unless You have a pathological conditions that requires the services.

### **E. Orthopedic Footwear**

We Cover orthopedic footwear when used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot, or to support a weak or deformed structure of the ankle or foot or to form an integral part of a brace. Coverage includes shoes, shoe modifications or shoe additions. We do not Cover sneakers and athletic shoes.

### **F. Family Planning Services**

In addition the Family Planning Services described in Section [], You may receive certain Family Planning and Reproductive Health services either from one of Our Participating Providers or from any appropriate Medicaid health Provider of Your choice. You do not need a referral from your PCP to obtain these services. If You visit any appropriate Medicaid health Provider, the cost to You will be the same as the cost of seeing on of Our Participating Providers.

The following are the Family Planning and Reproductive Health services that You

may receive from any Medicaid health Provider or a Participating Provider:

1. Screening, related diagnosis, ambulatory treatment, and referrals to a Participating Provider as needed for dysmenorrhea, cervical cancer or other pelvic abnormalities.
2. Screening, related diagnosis, and referral to Participating Provider for anemia, cervical cancer, glycosuria, proteinuria, hypertension, breast disease and pregnancy.
3. HIV testing and pre-test and post-test counseling when performed as part of a Family Planning visit.

You must visit a Participating Provider in order to have the following Family Planning and Reproductive Health services covered by Us:

1. Infertility Treatment as set forth in the Family Planning Services described in Section [].
2. Routine gynecologic care, including hysterectomies, as set forth in Outpatient Services Section of this [Contract; Policy].
3. Any other Family Planning and Reproductive Health Services not specified above.

## **G. Non-Emergency Transportation**

In addition to the non-emergency ambulance transportation benefit in Section [], You are eligible for non-emergency transportation, which includes personal vehicle, bus, taxi, ambulette, and public transportation to medical appointments. You or Your Provider must call the vendor listed below to arrange transportation:

NYC (all boroughs): Medical Answering Services - 1-844-666-6270  
Long Island (Nassau and Suffolk): Medical Answering Services - 1-844-666-6270  
All other counties: Medical Answering Services – see below:

{Drafting note: if plan service area includes counties outside of New York City and Long Island, list the individual counties within plan service area and corresponding phone number from Medical Answering Services' website at <https://www.medanswering.com/locations/nys/> .}

You can access this information online at:

[https://www.emedny.org/ProviderManuals/Transportation/PDFS/Transportation\\_PA\\_Guidelines\\_Contact\\_List.pdf](https://www.emedny.org/ProviderManuals/Transportation/PDFS/Transportation_PA_Guidelines_Contact_List.pdf)

If possible, You or Your Provider should call the vendor at least three days before Your medical appointment and provide Your appointment date and time, its address, and the doctor You are seeing.

#### **H. Family Counseling**

If You are receiving, or in need of, treatment for a substance use disorder, We cover outpatient family counseling visits.