New York Essential Health Benefits

SERVICE	LIMIT
Outpatient Services	
PCP Office Visits (Injury or Illness)	No Limit
Specialist Visits	No Limit
Other Practitioner Office Visit (Nurse, Physician Assistant)	No Limit
Outpatient Surgery Physician/Surgical Services	No Limit
Hospice Services	210 days/year; also, includes 5 Bereavement Counseling sessions for member's family either before or after the death of the member.
Home Health Care Services	40 visits/year
Emergency Services	
Emergency Room Services	No Limit
Urgent Care Centers or Facilities	No Limit
Emergency Transportation/Ambulance	No Limit
Hospitalization	
Preadmission Testing	No Limit
Inpatient Hospitalization	No Limit
Inpatient Physician and Surgical Services	No Limit
Skilled Nursing Facility	200 days/year
Delivery and all Inpatient Services for Maternity Care	No Limit
Mental Health and Substance Use Disorder Services	
Mental/Behavioral Health Outpatient Services	No Limit
Mental/Behavioral Health Inpatient Services (including residential treatment)	No Limit
Substance Use Disorder Outpatient Services	No Limit
Substance Use Disorder Inpatient Services (including residential treatment)	No Limit
Prescription Drugs	
Enteral Formulas	No Limit
Generic Drugs	30-day supply per month *Mail Order up to a 90-day supply optional benefit
Preferred Brand Drugs	30-day supply per month *Mail Order up to a 90-day supply optional benefit
Non-Preferred Brand Drugs	30-day supply per month *Mail Order up to a 90-day supply optional benefit
Specialty Drugs	30-day supply per month *Mail Order up to a 90-day supply optional benefit
Off Label Cancer Drugs	30-day supply per month

SERVICE	LIMIT
Rehabilitative and Habilitative Services and Devices	
Outpatient Rehabilitation Services	60 visits per condition per plan year
Outpatient Habilitation Services	60 visits per condition per plan year
Chiropractic Care	No Limit
Durable Medical Equipment	**Coverage for standard equipment only. DME defined as Equipment which is 1) Designed and intended for repeated use, 2) Primarily and customarily used to serve a medical purpose, 3) Generally not useful to person in the absence of disease or injury, and 4) is appropriate for use in the home.
Inpatient Rehabilitation Services	60 days per plan year in a rehabilitation facility
	* Inpatient Short Term Rehabilitative Services (Physical, speech and occupational therapy).
Inpatient Habilitation Services	60 days per plan year
Hearing Aids	Limited to a single purchase (including repair/replacement) every three years.
	*Bone anchored hearing aids are excluded except when either of the following applies:
	For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
	For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.
	Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.
Prosthetic Devices - External	1 external prosthetic device per limb per lifetime, and the cost of repair and replacement due to normal wear and tear or if previous device outgrown
	Coverage includes wigs for members suffering from severe hair loss due to injury or disease or treatment of a disease (e.g. chemotherapy); coverage is available only for synthetic wig materials unless member is allergic to all synthetic wig materials
Internal Prosthetic Devices	Covered if improves or restores function of internal body part; includes implanted breast prostheses; includes repair and replacement.
Laboratory and Imaging Services	
Diagnostic Test (X-Ray and Lab Work)	No Limit
Imaging (CT/PET Scans, MRIs)	No Limit

SERVICE	LIMIT
Preventive and Wellness Services and Chronic Disease Management	
Preventive Care/Screening/Immunization	Mammography (limits based on age), cervical cytology, gynecological exams, bone density, prostate cancer screening, etc. per NYS mandates and ACA.
Gym Membership Reimbursement	$200/$100 every 6 months for member/spouse
	* Partial reimbursement for facility fees every 6 months if member attains at least 50 visits. ** May be substituted for other wellness benefits
Prenatal and Postnatal Care	No Limit
Pediatric Vision	
General Pediatric Services	Emergency, preventive and routine vision care
Vision examinations performed by a physician, or optometrist for determining the need for corrective lenses, and if needed, to provide a prescription.	The vision examination may include, but is not limited to:
	* Case history
	* Internal and External examination of the eye
	* Ophthalmoscopic exam
	* Determination of refractive status
	* Binocular balance
	* Tonometry tests for glaucoma
	* Gross visual fields and color vision testing
	* Summary findings and recommendations for corrective lenses
Prescription Lenses	At a minimum, quality standard prescription lenses provided by a physician, optometrist or optician are to be covered once in any twelve-month period, unless required more frequently with appropriate documentation. The lenses may be glass or plastic lenses.
Frames	At a minimum, standard frames adequate to hold lenses will be covered once in any twelve-month period, unless required more frequently with appropriate documentation.
Contact Lenses	Covered when medically necessary.
Pediatric Dental	
Emergency Dental Care	Includes emergency treatment required to alleviate pain and suffering caused by dental disease and trauma.
Checkup for Children (Preventive Dental Care)	Includes procedures which help prevent oral disease from occurring, including but not limited to:
	* Prophylaxis: scaling and polishing teeth at 6 month intervals
	* Topical fluoride application at 6 month intervals where local water supply is not fluorinated
	* Sealants on unrestored permanent molar teeth
	* Space Maintenance: unilateral or bilateral space maintainers will be covered for placement in a restored deciduous and/or mixed detention to maintain space for normally developing permanent teeth.

SERVICE	LIMIT
Basic Dental Care - Child (Routine Dental Care)	* Dental examinations, visits and consultations covered once within 6-month consecutive period (when primary teeth erupt)
	* X-ray, full mouth x-rays or panoramic x-ray at 36 month intervals, bitewing x-rays at 6-12 month intervals; and other x-rays as required (once primary teeth erupt)
	* All necessary procedures for simple extractions and other routine dental surgery not requiring hospitalization including preoperative care and postoperative care
	* In office conscious sedation
	* Amalgam, composite restorations and stainless steel crowns
	* Other restorative materials appropriate for children
Major Dental Care - Child (Endodontics, Prosthodontics, Periodontics and Oral Surgery)	Includes all necessary procedures for treatment of diseased pulp chamber and pulp canals, where hospitalization is not required.
	Removable: Complete or partial dentures including six months follow-up care. Additional services include insertion of identification slips, repairs, relines and rebases and treatment of cleft palate.
	Fixed: Fixed bridges are not covered unless
	1) Required for replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth;
	2) Required for cleft-palate treatment or stabilization; or
	Non-routine oral surgery, such as partial and complete bony extractions, tooth re-implantation, tooth transplantation, surgical access of an unerupted tooth, mobilization of erupted or malpositioned tooth to aid eruption, and placement of device to facilitate eruption of an impacted tooth.
	3) Required, as demonstrated by medical documentation, due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis.
	NOTE: Refer to the Medicaid Management Information System (MMIS) Dental Provider Manual for a more detailed description of services.

SERVICE	LIMIT
Orthodontia (Orthodontics)	Includes procedures which help to restore oral structures to health and function and to treat serious medical conditions such as cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankyloses of the temporomandibular joint; and other significant skeletal dysplasias.
	Orthodontia coverage is not covered if the child does not meet the criteria described above.
	Procedures include but are not limited to:
	* Rapid Palatal Expansion (RPE)
	* Placement of component parts (e.g. brackets, bands)
	* Interceptive orthodontic treatment
	* Comprehensive orthodontic treatment (during which orthodontic appliances have been placed for active treatment and periodically adjusted)
	* Removable appliance therapy
	* Orthodontic retention (removal of appliances, construction and placement of retainers)
Other Services	
Infertility Treatment	Member must be between ages of 21 and 44.
	* Covered services include: initial evaluation, evaluation of ovulatory function, postcoital test, hysterosalpingogram, treatment of ovulatory dysfunction, ovulation induction and monitoring with ultrasound, artificial insemination, hysteroscopy, laparoscopy and laparotomy, semen analysis, laboratory evaluation, endometrial biopsy, pelvic ultrasound, sono-hystogram, testis biopsy, blood test
	** Advanced Infertility is not covered.
Elective Termination of Pregnancy	1 treatment/year
	* Therapeutic termination of pregnancy unlimited
Family Planning Service for Women	No Limit
Sterilization Procedures for Men	No Limit

SERVICE	LIMIT
Chemotherapy	No Limit
Dialysis	No Limit
Breast reconstructive surgery following mastectomy, lumpectomy, or lymph node dissection	No Limit
Mastectomy Care	Length of stay for lymph node dissection, lumpectomy or mastectomy as determined by the patient and physician.
Diabetic equipment, supplies, education and self-management	No Limit
Autism spectrum disorder screening, diagnosis and treatment	Coverage includes ABA treatment and Assistive Communication Devices
Reconstructive and corrective surgery	Surgery to correct a congenital birth defect of dependent child or incidental to surgery or follows surgery necessitated by trauma, infection or disease.
Second Opinion (surgical)	Second surgical opinion on the need for surgery.
Second Opinion (Specialist - cancer)	Second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer.
Medical Supplies	As required for the treatment of a disease or injury, including maintenance supplies
Transplants	No Limit
	* Solely for transplants for surgeries determined to be non-experimental and non-investigational.
Oral Surgery	No Limit
	* Oral Surgery due to injury is limited to sound natural teeth only; oral surgery due to congenital anomaly; removal of tumors