# New York Essential Health Benefits

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>LIMIT</th>
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<tbody>
<tr>
<td><strong>Outpatient Services</strong></td>
<td></td>
</tr>
<tr>
<td>PCP Office Visits (Injury or Illness)</td>
<td>No Limit</td>
</tr>
<tr>
<td>Specialist Visits</td>
<td>No Limit</td>
</tr>
<tr>
<td>Other Practitioner Office Visit (Nurse, Physician Assistant)</td>
<td>No Limit</td>
</tr>
<tr>
<td>Outpatient Surgery Physician/Surgical Services</td>
<td>No Limit</td>
</tr>
<tr>
<td>Hospice Services</td>
<td>210 days/year; also, includes 5 Bereavement Counseling sessions for member’s family either before or after the death of the member.</td>
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<tr>
<td>Home Health Care Services</td>
<td>40 visits/year</td>
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<tr>
<td><strong>Emergency Services</strong></td>
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<tr>
<td>Emergency Room Services</td>
<td>No Limit</td>
</tr>
<tr>
<td>Urgent Care Centers or Facilities</td>
<td>No Limit</td>
</tr>
<tr>
<td>Emergency Transportation/Ambulance</td>
<td>No Limit</td>
</tr>
<tr>
<td><strong>Hospitalization</strong></td>
<td></td>
</tr>
<tr>
<td>Preadmission Testing</td>
<td>No Limit</td>
</tr>
<tr>
<td>Inpatient Hospitalization</td>
<td>No Limit</td>
</tr>
<tr>
<td>Inpatient Physician and Surgical Services</td>
<td>No Limit</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>200 days/year</td>
</tr>
<tr>
<td>Delivery and all Inpatient Services for Maternity Care</td>
<td>No Limit</td>
</tr>
<tr>
<td><strong>Mental Health and Substance Use Disorder Services</strong></td>
<td></td>
</tr>
<tr>
<td>Mental/Behavioral Health Outpatient Services</td>
<td>No Limit</td>
</tr>
<tr>
<td>Mental/Behavioral Health Inpatient Services (including residential treatment)</td>
<td>No Limit</td>
</tr>
<tr>
<td>Substance Use Disorder Outpatient Services</td>
<td>No Limit</td>
</tr>
<tr>
<td>Substance Use Disorder Inpatient Services (including residential treatment)</td>
<td>No Limit</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td></td>
</tr>
<tr>
<td>Enteral Formulas</td>
<td>No Limit</td>
</tr>
<tr>
<td>Generic Drugs</td>
<td>30-day supply per month *Mail Order up to a 90-day supply optional benefit</td>
</tr>
<tr>
<td>Preferred Brand Drugs</td>
<td>30-day supply per month *Mail Order up to a 90-day supply optional benefit</td>
</tr>
<tr>
<td>Non-Preferred Brand Drugs</td>
<td>30-day supply per month *Mail Order up to a 90-day supply optional benefit</td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>30-day supply per month *Mail Order up to a 90-day supply optional benefit</td>
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<tr>
<td>Off Label Cancer Drugs</td>
<td>30-day supply per month</td>
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<tr>
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<td>LIMIT</td>
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<tr>
<td><strong>Rehabilitative and Habilitative Services and Devices</strong></td>
<td><strong>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.</strong></td>
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<tr>
<td>Outpatient Rehabilitation Services</td>
<td>60 visits per condition per plan year</td>
</tr>
<tr>
<td>Outpatient Habilitation Services</td>
<td>60 visits per condition per plan year</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>No Limit</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td><strong>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.</strong></td>
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<tr>
<td>Inpatient Rehabilitation Services</td>
<td>60 days per plan year in a rehabilitation facility</td>
</tr>
<tr>
<td>Inpatient Habilitation Services</td>
<td>60 days per plan year</td>
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<tr>
<td>Hearing Aids</td>
<td>Limited to a single purchase (including repair/replacement) every three years.</td>
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<td>*Bone anchored hearing aids are excluded except when either of the following applies:</td>
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<td>For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.</td>
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<td>For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.</td>
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<tr>
<td></td>
<td>Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.</td>
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<tr>
<td>Prosthetic Devices - External</td>
<td>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</td>
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<td>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</td>
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<tr>
<td>Internal Prosthetic Devices</td>
<td>Covered if improves or restores function of internal body part; includes implanted breast prostheses; includes repair and replacement.</td>
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<tr>
<td><strong>Laboratory and Imaging Services</strong></td>
<td><strong>No Limit</strong></td>
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<tr>
<td>Diagnostic Test (X-Ray and Lab Work)</td>
<td><strong>No Limit</strong></td>
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<tr>
<td>Imaging (CT/PET Scans, MRIs)</td>
<td><strong>No Limit</strong></td>
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<tr>
<td><strong>Preventive and Wellness Services and Chronic Disease Management</strong></td>
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<tr>
<td>Preventive Care/Screening/Immunization</td>
<td>Mammography, cervical cytology, gynecological exams, bone density, prostate cancer screening, etc. per NYS mandates and ACA.</td>
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<tr>
<td>Gym Membership Reimbursement</td>
<td>$200/$100 every 6 months for member/spouse</td>
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<td>* Partial reimbursement for facility fees every 6 months if member attains at least 50 visits. ** May be substituted for other wellness benefits</td>
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<tr>
<td>Prenatal and Postnatal Care</td>
<td>No Limit</td>
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<tr>
<td><strong>Pediatric Vision</strong></td>
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<tr>
<td>General Pediatric Services</td>
<td>Emergency, preventive and routine vision care</td>
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<tr>
<td>Vision examinations performed by a physician, or optometrist for determining the need for corrective lenses, and if needed, to provide a prescription.</td>
<td>The vision examination may include, but is not limited to:</td>
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<td>* Case history</td>
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<td>* Internal and External examination of the eye</td>
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<td>* Ophthalmoscopic exam</td>
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<td>* Determination of refractive status</td>
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<td>* Binocular balance</td>
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<td>* Tonometry tests for glaucoma</td>
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<td>* Gross visual fields and color vision testing</td>
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<td></td>
<td>* Summary findings and recommendations for corrective lenses</td>
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<tr>
<td>Prescription Lenses</td>
<td>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.</td>
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<tr>
<td>Frames</td>
<td>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.</td>
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<tr>
<td>Contact Lenses</td>
<td>Covered when medically necessary.</td>
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<tr>
<td><strong>Pediatric Dental</strong></td>
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<tr>
<td>Emergency Dental Care</td>
<td>Includes emergency treatment required to alleviate pain and suffering caused by dental disease and trauma.</td>
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<tr>
<td>Checkup for Children (Preventive Dental Care)</td>
<td>Includes procedures which help prevent oral disease from occurring, including but not limited to:</td>
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<td></td>
<td>* Prophylaxis: scaling and polishing teeth at 6-month intervals</td>
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<td>* Topical fluoride application at 6-month intervals where local water supply is not fluorinated</td>
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<td>* Sealants on unrestored permanent molar teeth</td>
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<td>* 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.</td>
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<tr>
<td>Basic Dental Care - Child (Routine Dental Care)</td>
<td>* Dental examinations, visits and consultations covered once within 6-month consecutive period (when primary teeth erupt)</td>
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<td>* 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)</td>
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<tr>
<td></td>
<td>* All necessary procedures for simple extractions and other routine dental surgery not requiring hospitalization including preoperative care and postoperative care</td>
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<td>* In office conscious sedation</td>
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<td></td>
<td>* Amalgam, composite restorations and stainless-steel crowns</td>
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<td></td>
<td>* Other restorative materials appropriate for children</td>
</tr>
<tr>
<td>Major Dental Care - Child (Endodontics, Prosthodontics, Periodontics and Oral Surgery)</td>
<td>Includes all necessary procedures for treatment of diseased pulp chamber and pulp canals, where hospitalization is not required.</td>
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<td>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.</td>
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<td>Fixed: Fixed bridges are not covered unless</td>
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<tr>
<td></td>
<td>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;</td>
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<td>2) Required for cleft-palate treatment or stabilization; or</td>
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<tr>
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<td>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.</td>
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<tr>
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<td>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.</td>
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<td>NOTE: Refer to the Medicaid Management Information System (MMIS) Dental Provider Manual for a more detailed description of services.</td>
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<tr>
<td><strong>Orthodontia (Orthodontics)</strong></td>
<td>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 dysplasia. 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)</td>
</tr>
<tr>
<td><strong>Other Services</strong></td>
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<tr>
<td><strong>Infertility Treatment</strong></td>
<td>* Initial evaluation; semen analysis; laboratory evaluation; evaluation of ovulatory function; postcoital test; endometrial biopsy; pelvic ultrasound; hysterosalpingogram; sono-hystogram; testis biopsy; blood tests; and medically appropriate treatment of ovulatory dysfunction</td>
</tr>
<tr>
<td><strong>Elective Termination of Pregnancy</strong></td>
<td><strong>Advanced Infertility is not covered.</strong></td>
</tr>
<tr>
<td><strong>Family Planning Service for Women</strong></td>
<td>No Limit</td>
</tr>
<tr>
<td><strong>Sterilization Procedures for Men</strong></td>
<td>No Limit</td>
</tr>
<tr>
<td>SERVICE</td>
<td>LIMIT</td>
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<tr>
<td>Chemotherapy</td>
<td>No Limit</td>
</tr>
<tr>
<td>Dialysis</td>
<td>No Limit</td>
</tr>
<tr>
<td>Breast reconstructive surgery following mastectomy, lumpectomy, or lymph node dissection</td>
<td>No Limit</td>
</tr>
<tr>
<td>Mastectomy Care</td>
<td>Length of stay for lymph node dissection, lumpectomy or mastectomy as determined by the patient and physician.</td>
</tr>
<tr>
<td>Diabetic equipment, supplies, education and self-management</td>
<td>No Limit</td>
</tr>
<tr>
<td>Autism spectrum disorder screening, diagnosis and treatment</td>
<td>Coverage includes ABA treatment and Assistive Communication Devices</td>
</tr>
<tr>
<td>Reconstructive and corrective surgery</td>
<td>Surgery to correct a congenital birth defect of dependent child or incidental to surgery or follows surgery necessitated by trauma, infection or disease.</td>
</tr>
<tr>
<td>Second Opinion (surgical)</td>
<td>Second surgical opinion on the need for surgery.</td>
</tr>
<tr>
<td>Second Opinion (Specialist - cancer)</td>
<td>Second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer.</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>As required for the treatment of a disease or injury, including maintenance supplies</td>
</tr>
<tr>
<td>Transplants</td>
<td>No Limit</td>
</tr>
<tr>
<td>* Solely for transplants for surgeries determined to be non-experimental and non-investigational.</td>
<td></td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>No Limit</td>
</tr>
<tr>
<td>* Oral Surgery due to injury is limited to sound natural teeth only; oral surgery due to congenital anomaly; removal of tumors</td>
<td></td>
</tr>
</tbody>
</table>