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 Facility Fee	No Limit
Outpatient Surgery Physician/Surgical Services	No Limit
Hospice Services	210 days/year; also includes 5 Bereavement Counseling sessios for members 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	
Inpatient Hospital Services	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 Abuse Disorder Services	
Mental/Behavioral Health Outpatient Services	No Limit
Mental/Behavioral Health Inpatient Services	No Limit
Substance Use Disorder Outpatient Services	No Limit
Substance Use Disorder Inpatient Services	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 lifetime
Habilitation Services	60 visits per condition per lifetime
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 absense of disease or injury, and 4) is appropriate for use in the home.
Inpatient Rehabilitation Services	1 consecutive 60 day period per condition per lifetime in a rehabilitation facility.
	* Inpatient Short Term Rehabilitative Services (Physical, speech and occupational therapy).
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
	*Coverage for external repairs or replacement in adults.
	- Coverage for wigs made from human hair unless member is allergic to sythetic wig materials.
	**Additional coverage for external device replacement for children for devices that have been outgrown
	- Coverage includes wigs for members suffering from severe hairloss due to injury or disease or treatment of a disease (e.g. chemotherapy)
Internal Prosthetic Devices	Covered if improves or restores function of internal body part; includes implanted breast protheses; includes repair and replacement.
Laboratory and Imaging Services	
Diagnostic Test (X-Ray and Lab Work)	No Limit
Imaging (CT/PET Scans, MRI'I)	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.
Prenatal and Postnatal Care	No Limit
Pediatric Vision	
Vision examinations performed by a physician, or optometrist for the purpose of 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 examinaion of the eye
	* Opthalmoscopic 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 maintatin 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 at 36 month intervals, if necessary, bitewing x-rays at 6-12 month intervals, or panoramic x-rays at 36 month intervals if necessary; 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 and Prosthodontics)	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;
	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.
Orthodontia (Orthodontics)	NOTE: Refer to the Medicaid Management Information System (MMIS) Dental Provider Manual for a more detailed description of services.
	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); ankylosis 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)

SERVICE	LIMIT
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.
	** 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
Chemotherapy	No Limit
Prostate cancer screening	Annual for men age 50 and over; age 40 and over if family history or risk factors; any age if prior history.
	* Includes exam and antigen test, per mandate.
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	680 hours per plan year for ABA treatment and coverage for 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.
Bariatric Surgery	No Limit
Transplants	No Limit
	* Solely for transplants for surgeries determined to be non-experimental and non-investigational.

SERVICE	LIMIT
Oral Surgery	No Limit
	* Oral Surgery due to injury is limited to sound and natural teeth only; oral surgery due to congenital anomaly; removal of tumors and cysts requiring pathological examination of jaws/cheeks/lips; for the correction of a non-dental physiological condition which has resulted in a sever functional impairement and surgical/nonsurgical medical procedures for temporomandibular joint discorders and orthognathic surgery