MEDICAL MUTUAL®

essential benefits

2015 Essential Health Benefits (51+ Groups)

The Affordable Care Act (ACA) defined 10 broad categories[1] of Essential Health Benefits that insurers must include in individual and small group plans (1–50 full-time equivalent employees for plans sold on the Health Insurance Marketplace; 1–50 eligible employees for plans sold off the Health Insurance Marketplace). Groups with 51 or more employees are not required to cover all Essential Health Benefits; however, those Essential Health Benefits that are covered in a large group plan cannot have dollar limits and must accumulate to the out-of-pocket maximum. The following are Ohio's Essential Health Benefits:

Essential Health Benefits

- Abortions (therapeutic)
- Allergy testing and treatment
- Ambulance
- Anesthesia
- Autism
- Cochlear implants
- Dental care for children to age 19 (includes checkup, basic care, major care, medically necessary orthodontia)[2]
- Dental services for accidental injury and other related medical services
- Diabetes education and training
- Dialysis
- Drugs (generic, preferred brand and non-preferred brand)
- Drugs and biologicals (specialty drugs and therapeutic injections)
- Durable medical equipment and medical supplies
- Emergency room and care
- Endoscopic services (all preventive and diagnostic)
- Evaluation and management office visits (primary care, specialists and urgent care)
- Genetic testing
- Hearing evaluation and audiology testing (to age 21)
- Home health services
- Hospice services
- Imaging (CT/PET scans and MRIs)—preventive and diagnostic
- Immunizations
- In-hospital physician visits/consultations
- Infusion therapy
- Labs, X-rays and medical tests (all preventive and diagnostic)
- Maternity—obstetrics, delivery, pre and postnatal care
- Mental/behavioral health and substance abuse disorder inpatient and outpatient services
- Organ transplants (including donor search)
- Organ transplant services (travel, meals, lodging and transportation)
- Outpatient therapy (cardiac rehabilitation, chemotherapy, chiropractic services, occupational, physical, pulmonary, radiation, respiratory and speech)
- Physical rehabilitation (inpatient)
- Preventive services covered under the ACA
- Private duty nursing
- Prostate specific antigen (PSA) (preventive and diagnostic)
- Room and board (semi-private room)
- Skilled nursing facility
- Sterilization—male and female (female covered under well women's preventive services)

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Essential Health Benefits (cont.)

- Surgery (inpatient, outpatient and ambulatory)
- Temporomandibular Joint Disease (TMJ)
- Vision—routine eye exam (all ages) and hardware (to age 19)[2]
- Wigs (following cancer treatment)

Non-Essential Health Benefits

Non-Essential Health Benefits are benefits that are not required to be covered under a plan.

- Abortions (elective)
- Acupuncture
- Bariatric surgery
- Biofeedback
- Cosmetic surgery
- Dental care (adult)
- Dental orthodontia (cosmetic)—child
- Education and training (non-diabetic)
- Hearing aids / hearing aid evaluation / dispensing / fitting / repair / conformity
- Hearing evaluation and audiology testing for adults (age 21 and older)
- Hypnosis
- Infertility treatment
- Learning disability (not classified as mental health)
- Long-term care
- Non-emergency use of the emergency room
- Non-emergency care when traveling outside the US
- Room and board (private room)
- Routine foot care
- Vision hardware—adults

Additional Information about Essential Health Benefits

This document is intended to be a summary of benefits provided by Ohio's benchmark plan as required by the Affordable Care Act. These lists are subject to change upon issuance of additional regulations or guidance.

The implementation of Essential Health Benefits may not discriminate based on an individual's age, expected length of life, present or predicted disability, quality of life or other health conditions.

Large Group (51+) Essential Health Benefit Guidelines: Essential Health Benefits are not required to be covered. However, any Essential Health Benefits that are covered must accumulate toward a Maximum Out-of-Pocket amount. For 2015, the Maximum Out-of-Pocket is $6,600 for single coverage and $13,200 for family coverage for individuals who do not have a high-deductible health plan (HDHP)/Health Savings Account (HSA); or $6,450 Single/$12,900 Family for those who do not have a HDHP/HSA. The Maximum Out-of-Pocket is the sum of any applicable deductible, coinsurance and copays for medical and drug services. Annual dollar limits are still prohibited on Essential Health Benefits.

Footnotes:

1. The 10 Essential Health Benefits categories are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness, and chronic disease management; and pediatric services, including oral and vision care (to age 19).
2. Because these services can be purchased in stand-alone plans that are exempt from the ACA, the stand-alone or embedded status will impact whether or not dollar limits and maximum ot-of-pocket accumulation is appropriate.